Indiana Protection & Advocacy Services

Representing Individuals with Mental Illness

A Primer for Public Defenders

This training guide is intended to assist Public Defenders in understanding persons with mental illnesses in order to work and interact more effectively with their clients.

The information and procedures set forth in this practice manual are subject to constant change. This primer should serve only as a foundation. Further investigation and study of the mental health, current law and procedures as related to the subject matter is warranted. Further, the forms contained within this manual are samples only. Forms were designed for use in a particular situation to address certain needs which these documents met. All information, procedures and forms contained herein should be very carefully reviewed and should serve only as a guide for use in specific situations.

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While this publication is intended to provide basic information, it is neither medical nor legal advice. Attempts were made to ensure its accuracy; the reader should direct their questions concerning specific situations to the psychiatrist, legal aid society or private attorney of their choice.

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INTRODUCTION

The 2001 Indiana Public Defenders' Study

Public defenders represent persons with mental illnesses in civil and criminal legal proceedings. The outcomes of these proceedings affect their clients' treatment and liberty. How well public defenders represent their clients with mental illnesses depends, in part, on the defenders' perceptions of the individuals with mental illness, their experiences with them, and the particular demands placed on them when the client is actively exhibiting symptoms of their mental illness.

In 2001 Indiana Protection and Advocacy Services conducted a survey through a contract with the Indiana University School of Criminal Justice to assess what the state's nearly 900 public defenders knew about mental illness and individuals with mental illness.

The study revealed, of those who responded:

- 98.5% of the public defenders have persons with mental illness on their caseloads;
- 85% of the public defenders reported that their education did not prepare them for working with persons with mental illness;
- 84.7% of the public defenders believe that cases involving clients with mental illness are "different";
- 65% of the respondents reported that law school preparation regarding mental health law was "poor";
- 60% of the public defenders reported having difficulty communicating with clients with mental illnesses;
- 54.4% of the public defenders believe that clients with mental illnesses consume more than their fair share of time;
- 50.6% of the respondents reported that they did not know very much about mental illness; and,
- Only 35% have had any continuing education on mental health law.

Goals of Training

- To increase understanding of mental illness and the impact on the affected individuals.
- To increase effective communication skills and reduce frustration when dealing with clients with mental illness.
- To minimize the amount of time people with mental illness are involved in the legal system.
- To increase understanding of the rights of people with mental illness.
- To know how to access treatment in Indiana.

Topics to be covered

- Myths
- Basics of mental illness
  - Causes
  - Behavioral observations
  - Multiaxial Assessment
- Major mental illnesses
  - Schizophrenia
  - Bipolar Disorder a.k.a. Manic Depressive Disorder
  - Depression
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How to Use this Document

This document was intended to provide an overview to assist public defenders in understanding persons with mental illnesses in order to work and interact more effectively with the client. It is not intended to enable the reader to become medically proficient in the area of mental illness. It is intended to be the first step to opening the door to greater understanding of mental illnesses. The study of psychiatry is a complex issue which can not

be captured in totality in a small study guide. However, with basic working knowledge, the primer will assist the public defender in serving persons with mental illnesses.

The **BASICS OF MENTAL ILLNESS** gives an overview. This chapter explains the importance of behavioral observations and the Global Assessment of Functioning.

The chapter on **MAJOR MENTAL ILLNESSES** provides an overview of the most common mental illnesses. In this chapter, **Characteristics** are identified for each disorder with the corresponding **Behaviors** outlined. **Treatment Options** explains common approaches and anticipated effects of medication. **Strategies for Communication** are those specific to each disorder.

The **SUBSTANCE RELATED DISORDERS** chapter discusses substance use which has a negative impact on the person's ability to function and how that may effect an individual's mental health status. Again, **Characteristics, Behaviors, Treatment Options and Strategies for Communication** are outlined.

The **DEVELOPMENTAL DISABILITIES** chapter compares the similarities and the impairment on one's functioning level.

The chapter on **TREATMENT OPTIONS** gives an overview of treatment alternatives for persons with mental illnesses. Medication, outpatient treatment, inpatient services, and state hospital care are all part of the continuum of therapeutic interventions.

The **MEDICATION** chapter discusses types of medications as well as the positive and negative effects. It is important to remember that a medication may have different effects on different individuals.

The chapter on **COMMUNICATION TECHNIQUES** presents principles and suggestions for positive interactions with a person who is symptomatic. Anger may be a presenting problem during interviews; suggestions are made to manage anger and to avoid a behavioral outburst.

The **LEGAL CHALLENGES** chapter offers information on **Mental Health Commitments**, **Informed Consent** and **Preparation for Court.**

Chapter
2

MYTHS

False - People with schizophrenia have many personalities.

True – Schizophrenia is not a multiple personality disorder.

False – People who are mentally ill are dumb.

True – A person with a mental illness is not necessarily mentally retarded and may have an average or above average I.Q.

True – A person with mental retardation may or may not have a mental illness.

False – People who are mentally ill can't take care of themselves.

True – Being mentally ill does not mean a person is incompetent.

True – A person who is incompetent may be so due to a large variety of factors.

False – Persons with schizophrenia are dangerous.

True – People are people, not diagnoses.

True – People with schizophrenia are no more dangerous than the general public.

False – Mentally retarded people can't learn.

True – People with mental retardation learn at a slower rate and may require alternative techniques or repetition to learn new things.

False – People with mental illness can't work.

True – Most people with mental illness can hold jobs, but their illness may require them to take time off from work, just like a person with asthma might need to take time off work periodically.

False – Once a person is mentally ill, there is no hope for them.

True – People with mental illness can lead productive lives if they receive treatment, take medication and establish routines.

False – Mentally ill people don't know what's good for them.

True – People with mental illness have wants, needs and desires like everyone else.

True – People with mental illness can make informed decisions.

False – Older adults who are mentally ill can't change, so treatment is useless.

True – Treatment can help people of all ages lead happier, more productive lives.

False – Mental illness is a personal failure, a sin.

True – Mental illness may be due to a product of a chemical imbalance in the brain, life experiences and/or environmental factors.

False –Mentally ill people are violent.

True – The prevalence rate for violence among people with mental illnesses is reflective of that of the general population.

False –The mentally ill stop taking their medications more often than other people do.

True – Persons with mental illnesses need to have their medications adjusted, or fine-tuned, to reach a maximum therapeutic benefit. Some individuals may try alternative medications to relieve the stress of their symptoms.

True – Not only individuals with mental illness stop taking their medications, a large number of the general population do not take their medications as prescribed.

False –Mentally ill people should be locked away.

True – Persons with mental illnesses can hold jobs, raise families, pay taxes and otherwise live normal lives. New generation medications, which are constantly being discovered, have enabled individuals with mental illness to live productively in their home communities.

Chapter

3

BASICS OF MENTAL ILLNESS

Mental illness can be anything from mild anxiety to florid psychosis. There are many different types of mental illness, but all have in common the severe disturbances of behavior, mood, thought processes and/or social and interpersonal relationships.

People with mental illness are responsible for their own actions. However, their illness should be taken into consideration while processing through the legal system.

Causes

Most researchers believe that both biological and psychological risk factors are causes for mental illnesses. Some disorders may be caused wholly, in part or in combination with biochemical or structural abnormalities in the brain. Life experiences and environmental factors may also contribute to mental disorders in those people who are susceptible. Psychological factors, such as prolonged exposure to negative social conditions, can also lead to some disorders.

Behavioral observations

Behavioral observations are the clues you see when talking to someone. The person is wringing his hands, pacing, and/or sweating. These may be normal behaviors for the person, or newly developed ones. Some people may present with odd behaviors that do not impair their ability to function. However, if an individual's behaviors impede or impair his ability to function, then clinical assessment is warranted. A treatment clinician needs to have a period of time in which to observe an individual in order to determine the extent of the functional impairment, if any.

An individual may appear very high functioning and stable during a 5 to 10 minute meeting with you. In a 30-minute meeting, a person's symptoms may become more evident. You may experience the person's inability to focus on a topic for more than 5 or 10 minutes, their loss of train of thought or topic jumping. If asking open ended questions leads to the client becoming tangential and difficult to re-direct, structure the environment by asking more specific yes/no questions.

Multiaxial Assessment & the Global Assessment of Functioning

As a public defender, you may request psychological data in order to better understand the individual. In this documentation the psychiatrist, psychologist or other clinician may refer to the "GAF score". The Global Assessment of Functioning score is a subjective clinical judgement and a component of the multiaxial assessment.

The Multiaxial Assessment references Axes I, II, III, IV, V.

- Axis I is intended to reference the clinical disorder (except personality disorders and mental retardation).
- Axis II identifies diagnoses of personality disorders or mental retardation.
- Axis III is used for reporting medical conditions that may have an impact on the psychiatric disorder.
- Axis IV is designed to identify psychosocial and environmental problems that may have an impact on the diagnosis, treatment, and/or prognosis.
- Axis V is the GAF score.

The Global Assessment of Functioning is a component of the multiaxial assessment process which is outlined in the American Psychiatric Association's Diagnostic and Statistical Manual IV-TR (DSM). It is a subjective tool used to provide some measure of how an individual is functioning in the psychological, social and occupational realms. The GAF is used in planning treatment, measuring the impact of treatment and measuring the outcome of treatment. The GAF scale ranges from zero to 100. Zero represents inadequate information; whereas, 100 represents superior functioning. A 50 indicates serious problems such as suicidal ideation, frequent shoplifting and unable to keep a job. A score of 60 reflects moderate difficulty in social, occupational or school functioning such as conflict with peers or co-workers and occasional panic attacks. It is important to remember that past behavior is the best predictor of future behavior.

Chapter

4

MAJOR MENTAL ILLNESSES

Schizophrenia

Schizophrenia disorders are diseases of the brain which cause unrealistic thoughts and feelings. The disorder is most likely caused by a chemical imbalance in the brain. The person may have a genetic predisposition for this disease, especially if a parent or other relative has been diagnosed with this disorder. Therefore, it is very helpful to determine whether other family members suffer from a mental illness.

Characteristics

There are a wide variety of characteristics of schizophrenia. An individual may exhibit some or all of these characteristics with a range of intensity levels.

1. The person creates her own reality.

2. Delusions – The individual has thoughts and beliefs about things that do not exist or are distorted, but are that person's reality. For example, Joe thinks he is the President of the United States.

3. Hallucinations – The individual has sensory distortions which are a part of the psychotic ideation process. Auditory hallucinations, which are the most common, are when people hear things that are not occurring. Frequently, people hear voices of others. These voices may be patronizing, mean spirited, commanding or comforting. Visual hallucinations occur when the person sees other people or things that are not present. These visions may range from comforting, to bothersome or scary. Olfactory hallucinations occur when the person smells odors which are not present in the environment. Tactile hallucinations occur when the individual feels things that are not present in the environment. For example, a person may feel as if spiders are crawling on them. Different types of hallucinations may occur in tandem. A person may see and feel spiders crawling on his/her body.

   Public defenders are urged to carefully gather information about what role hallucinations may have played in the alleged criminal activity.

4. Disorganized speech – The person may talk in a fragmented speech pattern. As an indication of disorganized thinking, the person may jump from topic to topic without an apparent connection.

5. Inappropriate affect – It is an inappropriate expression of an emotional response to a situation. Affect may be blunted or flattened where the individual appears dull or slow to respond. The person may not be processing what is being said to him because he is preoccupied with what is going on inside his head, such as thoughts, delusions or hallucinations.

6. Lack of motivation – the person does not appear interested in changing the situation or making it better.

7. Irrational thought processes – The individual draws conclusions based upon little, if any, fact. Delusions can become the individual's reality. The person can do lots of topic jumping which make sense and has a logical progression to her, but makes no sense to anyone else.

8. Expressed odd beliefs – For example, the person may believe he is protected from aliens by putting aluminum foil on his head, over the windows, etc. The person may believe that he has a hook in his throat and that is why he has a sore throat.

Behaviors

Many observable behaviors of persons with schizophrenia are due to reactions to internal stimuli or the side effects of medication.

1. Disorganized behavior – The person may exhibit bizarre body movements which make a person look odd. For example, you might see repetitive movements (rolling tongue), facial grimacing, shuffling gait, or excessive motor activity.

2. Self-talk – The person may be talking aloud to no one in particular. This may be in response to hallucinations. It could be a coping skill aimed at calming or organizing the person's behaviors.

3. Physical gesturing – The person may strike out, have eye movements or make gestures in response to their hallucinations.

4. Paranoid reactions - Persons with paranoia may express fears that others are out to get them, may use multiple locks on doors, or may isolate themselves. Isolation due to paranoia is usually a self-protection coping mechanism where the individual seeks to reduce external stimuli in order to avoid perceived harm.

5. Isolation – The individual may separate herself from others due to a difficulty in communicating. Perhaps the words elude the person, the person can not label the feeling or emotion, or the person may not be able to respond to multiple voices. At times, the person may avoid others to keep them from observing their symptoms.

6. Impaired spontaneity – The person may be slow to respond to situations. The individual may not be processing what is happening in his/her environment and/or be unsure of how to respond thereby doing nothing.

7. Agitation – The person may become upset without an apparent trigger. You may observe pacing, finger rolling, eye rolling, heavy breathing, loud speech, verbal threats or threatening posture.

Treatment Options

Treatment with medications can enable a person to function in a reality-based manner and be more aware of their surroundings.

Medication partnered with psychosocial rehabilitative programs and other services will contribute to the most positive prognosis for the individual. Typically, individuals who are seriously mentally ill with schizophrenia may need the structure and repetition of day treatment programs. Due to the cyclic nature of schizophrenia, some individuals may require periodic, brief inpatient psychiatric hospitalizations to stabilize their symptoms. In most cases, stabilization is the result of medication adjustments.

Treatment is of a long-term nature.

Strategies for Communication

- Maintain eye contact.
- Use short, concise sentences. Do not ramble.
- Make sure the person can focus on you rather than their symptoms.
- Use a quiet room.
- If the person is paranoid, include a significant other that can convey trust to the individual. Be cautious of any implications this may have concerning client privilege.

Bipolar Disorder

Bipolar disorder causes dramatic mood swings, from overly "high" and/or irritable to sad and hopeless and then back again, often with periods of normal mood in between. Severe changes in energy and behavior go along with these changes in mood. The periods of high and lows are called episodes of mania and depression.

Characteristics

1. The person may exhibit periods of mania or a frantic "high".
2. The individual may display an oversupply of confidence and energy leading to unrestrained, uncontrolled behavior.

3. The person may experience devastating lows characteristic of depression. The depression may be so severe that the individual cannot complete activities of daily living, cannot deal with family problems and/or experience poor work performance.

4. Individuals may show little interest in activities that usually bring pleasure to their lives.

Behaviors

During the manic phase the person may:

1. be hyperactive;

2. experience delusions;

3. have racing thoughts and speech;

4. experience sleeplessness without feeling tired;

5. display impaired judgment;

6. be easily distracted and have an impaired ability to focus;

7. be hyper-focused; and/or,

8. spend excessive amounts of money resulting in a depletion of savings or indebtedness.

During the depressive phase the person may:

1. display excessive sleep or lack of sleep;

2. be unable to concentrate;

3. experience weight gain or weight loss; and/or,

4. make suicidal gestures.

Treatment Options

Medication partnered with psychotherapy can be very effective. Depending upon the severity of the illness, some people can do well with outpatient psychotherapy while others require the structure of a day service program. Individuals with this disorder may benefit from services across the entire array of mental health treatment depending upon the intensity of symptoms.

Strategies for Communication

- Determine which phase the person is experiencing at the current time.

- During a manic phase, use a directive approach, maintain eye contact, have the individual repeat what has been said, and set timelines for tasks.

- During a depressive phase use, a supportive approach, outline expectations and set timelines for tasks.

Depression

Situational depression is understandable and expected after the death of a loved one, a natural disaster, divorce, etc. Chronic depression is a medical condition that can affect the way a person thinks and acts. This is the most treatable mental illness.

Characteristics

1. One may experience extreme sadness, be tearful the majority of the time, be unable to see any positive in his or her life, and/or have a prevailing feeling of "doom and gloom". The individual's level of sadness does not seem to be at an appropriate level of intensity for the trigger.

2. The person may experience extreme irritability, be easily agitated, or be cranky. You may be unable to identify what sets the person off.

3. The individual may have experienced a loss of interest in usually pleasurable activities. One may isolate and no longer associate with friends. The person may make up excuses of why she can not participate in activities that she used to enjoy.

4. Individuals often have difficulty in concentrating and in memory recall. This is often noted in their work performance. The person may have difficulty completing a task. You may be asked to repeat things. At times, the individual can not remember routine information such as the day of week, telephone number, etc.

5. The person may have difficulty in making decisions. She is unable to concentrate and focus; it is difficult or too much work to make decisions. Someone may not make a decision rather than make the wrong one.

6. This person may have suicidal thoughts or thoughts of self-injurious behaviors. One may talk about wanting to kill him/herself. The public defender should ask if the client is having thoughts about the suicidal method that might be used to assess the degree of risk or lethality. A person who verbalizes a plan or a means should be taken very seriously.

7. The person may have a change in eating habits resulting in weight loss or gain. The change may be to console or to deprive oneself. If a noticeable amount of weight change is observed over the course of a month's time, then the public defender should suspect depression and make an appropriate referral for evaluation.

8. Individuals with depression may experience disturbances in sleep habits. There may be complaints of excessive sleep or insomnia. This, too, can effect the ability to concentrate and to recall information. The person may talk about going to bed late and getting up early. Is this a normal sleep pattern or is it a change?

9. The person may complain of loss of energy and fatigue. It may be due to loss of sleep or changes in sleep habits. For an individual who is very lethargic in their behaviors, it may relate back to the loss of pleasure in activities.

10. The individual may express feelings of worthlessness. She does not think anything she does is good enough. She sees no value in herself, or how to make a positive contribution to the home or work environment.

11. The person may encounter overwhelming feelings of guilt and without reason. You may hear statements such as "I shouldn't have done that", I'm such a bad person", "I did a bad thing." Such individuals may tend to assume the problems of the world when they really have nothing to do with it or did not do anything to cause the problem.

12. The individual may complain of unexplained physical discomfort, such as headaches, backaches, and stomachaches.

Behaviors

During depressive episodes the individual may demonstrate:

1. Extreme tearfulness;

2. Social isolation;

3. Expressions of worry, rumination;

4. In severe cases the person is unable to complete tasks; for example grooming, housekeeping, work, childcare, etc.

5. Very slow speech;

6. Very slow body movement or reduced motor activity;

7. Increased alcohol consumption; and/or

8. Frequent negative statements, "I hate myself" "I'm not worth the trouble" " I can't do anything right" "I don't know why I'm on this earth"

Treatment Options

Antidepressant medication and psychotherapy, which could include stress management and other coping skills.

Strategies for Communication

- Word statements and questions in a positive manner. "Tell me about X", "What is important about Y".
- Discussions should be goal directed.
- The individual should not be asked to make multiple decisions during one session.

Anxiety

The person with an anxiety disorder is overwhelmed with tension when there is no real danger. This individual will take extreme action to avoid the source of the fretfulness. The person's worry is out of proportion to the situation.

Characteristics

1. The person is overwhelmed with excessive worry and finds it impossible to control the apprehensiveness.
2. The individual is very restless. The person feels on edge, cannot relax and may obsess over things they cannot control.
3. The individual may have difficulty concentrating. This can effect work performance because the person has trouble completing a task and needs to ask repeatedly for instructions.
4. Individuals with an anxiety disorder may experience disturbances in their sleep habits. The person may not be able to fall asleep due to worrying or rumination.
5. Persons may become easily agitated. The person can become so anxious that they are easily agitated by simple, routine questions.
6. The individual may experience feelings of fear; always thinking that something bad will happen. The person may be afraid because she cannot control everything in his/her environment.
7. The individual may experience muscle tension. This person is unable to relax resulting in physical discomfort and pains.

Behaviors

During an episode of acute anxiety, the person may:

1. Have difficulty breathing;

2. Rapid heart rate;

3. Have hand tremors;

4. Experience profuse sweating;

5. May have racing thoughts and reports s/he has too many things going on in their head to concentrate;

6. Have headaches;

7. Pace the floor;

8. Pray excessively or in an unusual situation or setting;

9. Have panic attacks where the individual becomes immobilized, and hyperventilates. The individual may feel s/he may pass out, have a heart attack or is going to die. Some individuals may report a sense of claustrophobia. Some panic attacks are unpredictable, while others are triggered by extreme stress and tension;

10. Be unable to identify the source of worry;

11. Be unable to stay focused on a discussion;

12. Be resistant to shaking hands;

13. May make comments about ‘’nothing is going to be right” ;

14. May possess a “doom and gloom” attitude; and/or

15. Be unable to answer questions and report that his/her “mind went blank”.

Treatment Options

Medications are used with other forms of therapy/treatment to help reduce the symptoms. It may take trial and error to find the most effective medication and dosage for the person.

Stress management and relaxation therapies are important coping skills for the person to learn.

Cognitive-behavioral therapy takes the thoughts the person has, looks at how irrational these thought may be and helps the person learn how to identify false beliefs, or mistaken ideas. The person learns to replace anxious thoughts with positive, reasonable ones.

Successful treatment may take longer than the individual wishes. Positive reinforcement is important for those small measures of success.

Healthy lifestyle changes are important for the person to manage stress. Diversions, which include community service work, may be beneficial to help the person focus on something

besides their own worries. Encourage good nutrition, exercise, relaxing activities and avoid alcohol and other non-prescribed drugs.

Strategies for Communication

- If the person has a panic attack in your office, reduce the noise levels, encourage the person to do deep breathing, and have the person sit down. If the person is unable to calm down, you may need to call 911.
- Have the individual repeat back any directives given.
- Have person take notes.

Obsessive - Compulsive Disorder

Obsessive – Compulsive Disorder is a mental illness characterized by a person's obsessions (which are unwanted thoughts, images and impulses) which interfere with their daily living and leads to excessive worry, anxiousness and discomfort. At the same time, the person may have compulsions (which are repeated behaviors) that are in response to the obsessive thoughts and are difficult to control. The person suffering from this disorder believes that if they perform these ritualistic behaviors it will reduce stress and anxiety. However, it becomes a vicious cycle that the person can not break. The individual may spend all of their time on these obsessive thoughts and compulsive rituals so they are not able to give time to work, school or raising a family.

For a person diagnosed with this disorder, stealing may be a symptom of the disorder. The person is trying to control his/her life by obtaining what they feel is necessary to reduce concerns and level of stress.

Characteristics

The characteristics and behaviors of this disorder are very closely linked. The obsessions could be one or a combination of several irrational thoughts.

1. Impending doom;
2. Fear for one's safety;
3. Cleanliness, or lack of cleanliness;
4. Hitting "hard times " and having nothing;
5. A need to be "in control";
6. Worrying; and/or
7. Fear of getting fat.

Behaviors

The behaviors related to this disorder are the person's actions. The compulsions could be behaviors such as:

1. Fretting;

2. Thought games where sayings, sequences and/or prayers are said to oneself repeatedly to try to gain control over the environment;

3. Repeated checking of the stove, smoke detectors, locking and re-locking doors, etc. Switching light switches on and off, opening and closing doors;

4. Repeated cleanliness behaviors such as handwashing, vacuuming, dusting, showering, etc.;

5. Buying and storing large quantities of food, clothes, and other items which are kept for "emergencies". The person may collect newspapers, soda cans, or other items which others usually toss out;

6. Organizing, re-organizing to have everything in its place. The person may spend hours arranging and rearranging;

7. Hand wringing, pacing, and ruminating are outward signs of worrying. There could also be other less visible signs or no outward behavior of worrying;

8. Excessive exercise and dieting may lead to extreme weight loss;

9. Late or missed appointments because the person is too busy checking and re-checking or washing to leave home;

10. Repeatedly excusing himself from an appointment to go wash hands;

11. Making numerous, unnecessary medical appointments which would interfere with appointments with the public defender;

12. Drinking, gambling or overeating may also be related behaviors.

Treatment Options

Medication is often prescribed to curb the obsessions. Behavior therapy may also be used to teach people how to change their maladaptive behaviors into more appropriate, constructive ones that will still meet their needs. Developing a support system to assist in breaking the cycle of rituals and provide reassurance can also be helpful.

Strategies for Communication

- Provide client with very specific instructions of what is expected including dates, times and even what to wear.

- Conduct meetings in a clutter free room.

Antisocial Personality Disorder

A person with an antisocial personality disorder has a total disregard for the rules and the rights of others.

Characteristics

1. The person may be very charming, yet lacks a moral component.
2. The individual fails to obey rules established by society.
3. There is no sense of guilt demonstrated nor are any feelings of remorse demonstrated for one's actions.
4. The person can rationalize his/her behavior and sound very convincing.
5. The person tells lies, leaves false impressions and purposefully misleads others.
6. The person is very skillful in convincing others to do what he wants done, like a con-artist. He may recruit others. The individual is very charismatic and can easily manipulate others into believing that this is in their best interest. The person thinks others should take care of him/her.
7. The individual is impulsive which relates to the need for immediate gratification. There is little regard for what may happen to others because of his or her behavior.
8. The person is irresponsible and does not look at the long term consequences of their behavior nor do they care. There is more concern with immediate gratification and being is able to manipulate others and in turn avoid the immediate consequences of his or her behavior.
9. The individual is likeable until confronted with facts and caught at manipulations. When another sees through the charade, then the person can become verbally aggressive.
10. Individuals with antisocial personality disorders can be very manipulative and convincing.

Behaviors

The individual with an anti-social personality disorder may:

1. Not be able to keep a job for an extended period of time;

2. Blame their failures on other people;
3. Not take care of his/her financial responsibilities;
4. Not develop meaningful long-term relationships with others;
5. Not reside in one place for an extended period of time; and/or
6. The best indicator for future behavior is past behavior.

Treatment Options

With this type of personality disorder, change is difficult to achieve, although some individuals do respond positively to effective treatment. At times the best course of treatment may be the natural consequences of behavior.

Strategies for Communication

- Give directive comments and instructions.
- Do not allow time for extraneous conversations.
- Prepare an agenda and do not stray from the topics listed.
- Be aware that individual may portray himself as a victim, keep discussions based on fact and avoid opinions.
- Require verification of any actions taken. If you have given an assignment to complete a task, request proof that the task has been completed. A paycheck is verification of employment.

Borderline Personality Disorder

Borderline Personality Disorder is a mental illness that affects the individual's mood, self-image, and relationships with others. If the individual is highly "annoying" and regularly tests limits while being very dependent upon others, it is very possible that the person has a borderline personality disorder. The person may exhibit persistent patterns of instability in relationships with others, have a poor self-image, fluctuate in moods, and be impulsive.

Characteristics

1. While looking for immediate gratification, the person may take impulsive actions like buying expensive jewelry, having unprotected sex or maxing out a credit card.

2. The person is self-absorbed. Actions and beliefs are centered on wants and desires because of a poor self-image and fear of abandonment. The individual may equate wants and desires with basic needs.

3. The person is unable to establish lasting, meaningful relationships.

4. The individual is very dependent; afraid to be alone, but is also afraid of having close relationships and may be characterized as having a "love-hate" relationship with people.

5. The individual can be very charming and likeable while still demonstrating behaviors which are frustrating to others.

6. The person may give very emotional responses to comments and situations, which you would not anticipate would elicit such a drastic response.

Behaviors

The person with a borderline personality disorder may:

1. Call the public defender multiple times per day with seemingly minor issues or concerns;

2. Exhibit self injurious behaviors such as cutting on the arms and burning oneself with a cigarette;

3. Voice suicidal thoughts;

4. Express inappropriate emotions. Extreme emotionality makes it to moderate his/her emotions;

5. Have mood changes with subtle triggers that are not obvious to others;

6. Have difficulty controlling anger;

7. Express anger more intensely than the situation warrants;

8. Demonstrate attention-seeking behaviors by causing a scene in public, crying hysterically, and pleading for forgiveness;

9. Exhibit a variety of self destructive behaviors by burning him/herself with cigarettes, making superficial cuts, engaging in alcohol or drug use, and/or engaging in risky sexual behavior.

Treatment Options

An individual with a borderline personality disorder may be prescribed medication to control the symptoms of his/her depression, anxiety or impulsivity. Prescribing multiple medications is a typical course of treatment with individuals with this disorder.

Such individuals often require hospitalizations in either a medical/surgical unit or a psychiatric unit due to the self-injurious behaviors.

Persons can benefit from individual and group therapy to deal with issues of concern while improving social skills and behaviors.

Treatment is of a long-term nature.

Strategies for Communication

- Establish a structure for communication and for contacting you.
- Set boundaries and limits with the individual by allowing him/her to call only at designated times, making requests to you in writing, and preparing notes for his/her meetings with you.
- The public defender needs to remain calm and avoid over-reacting to the person's mood swings or attention-seeking behaviors.
- Stick to the facts when talking to the individual. Avoid hypothetical examples and "what-if" scenarios.
- When the person is pointing out injuries from self-harm, respond by not acknowledging the injuries, but by redirecting the person to the reason for the meeting. "I'm glad you are here for our meeting today so we can talk about X."
- Consistency is essential. It may be important to take notes in order to avoid any mixed messages, to reiterate items covered previously and to remain structured and focused during sessions with this individual.

Chapter

5

SUBSTANCE RELATED DISORDERS

Substance abuse is evidenced by a troublesome pattern of substance use which leads to impairment in their ability to function at home, work or school. Some individuals with mental illness will use alcohol or other substances to alleviate their symptoms or to substitute for other prescribed medications. Recovery is an ongoing process where an individual is able to lead a healthy, productive life without the use of alcohol or drugs.

Characteristics

1. Substance dependence is marked by the need for increased amounts of a substance(s) to achieve the desired effects.

2. The substance is taken in larger quantities or for longer periods of time.

3. The person devotes a great deal of time in activities aimed at obtaining the necessary substance and/or recovering from the effects.

4. The person excludes other social, recreational or occupational activities for the substance use.

5. The use continues despite knowledge and recognition that the substance is dangerous and impairs the person's life.

Behaviors

1. The person fails to perform work in their employment, at school or at home or has a generally poor work performance.

2. The individual has a record of repeated absences or tardiness at work or school.

3. Care of children, dependents and/or the household are neglected.

4. The person will operate machinery or a motor vehicle while impaired.

5. The person has re-occurring substance-related legal problems such as arrests for public intoxication, drunk driving and/or substance trafficking.

6. The individual has persistent problems with social or interpersonal relationships which are intensified by the effects of the substance.

7. The individual has arguments or physical fights over the substance use. There may be a record of domestic charges.

Treatment Options

Intensive Outpatient Programs (IOP) take a group approach to address substance abuse and dependence problems. The group process is a very therapeutic tool to address such issues. IOP provides the participant, in a psychoeducational model, information on the effects of various substances on the entire person, it allows for confrontation by peers to break down the defenses that stand in the way of recovery, and it can become a medium for developing coping skills to deal with life stressors which turned the person to substance use.

Aftercare programs are often an extension of IOP as a less intensive group process to provide support. Aftercare is also used as a tool to identify signs of relapse. It gives the person a forum to discuss ongoing abstinence challenges, identify life struggles and to develop additional coping skills necessary to maintain a healthy drug-free lifestyle.

Inpatient detoxification programs are sparse. Admission criteria for such services usually require a physical/medication justification for admission.

Support groups such as Alcoholics Anonymous and Narcotics Anonymous are very powerful aids to the person trying to recover. Support groups may be very effective tools to recovery for some individuals; however, some people may choose other spiritual outlets for support and guidance.

Strategies for Communication

- Do not attempt to conduct business with a person who is impaired.
- Be aware of the individual's attempts to rationalize his/her behavior.
- Choose your words carefully, some people who are impaired become more easily agitated.

Chapter
6

DEVELOPMENTAL DISABILITIES

The State of Indiana's definition of Developmental Disabilities is in I.C. 12-7-2-61 (2).

A person with a mental illness is suffering from an emotional problem or a chemical imbalance in the brain. This is distinctly different from a developmental disability. Use of the two terms "mental retardation" and "mental Illness" can become confusing because the two disorders may share common characteristics. Individuals with mental retardation may have a cognitive impairment that prevents them from understanding cause and effect. While a person with mental illness, when the symptoms are under control and stabilized, can understand cause and effect.

A person who has a mental illness is not necessarily mentally retarded, although the individual has functional impairments. A developmental disability may be more apparent in early childhood development, whereas a mental illness may not be apparent until late teens or adulthood. Persons with mental retardation and other developmental disabilities as well as people with mental illness are assessed by their functional skills and limitations. In the case of a person with a mental illness, functional impairments may be due to the interference of the psychiatric symptoms in the person's activities of daily living. At early ages, the psychiatric symptoms may impede normal social and emotional growth.

A person can be diagnosed with both disorders, which serves to compound the difficulties one experiences. Persons who are diagnosed with both a mental illness and a developmental disability may have different response rates to medications and medication changes.

Chapter

7

TREATMENT OPTIONS

There are no right or wrong treatment options for persons with mental illness. Preferred treatment options may be community-based, office-based, provided by a medical doctor or a paraprofessional. It is important for the consumer to be involved in their treatment choices.

Therapeutic interventions

Therapeutic interventions are those interventions or activities in which the person is involved that helps to relieve the symptoms. Diversion programs, which require strict adhesion with treatment, may be a better option.

Therapeutic interventions may include:

1. Traditional psychotherapy - individual, family and/or group counseling to address presenting problems.

2. Cognitive therapy – the recognition of troubling situations and the development of alternatives and solutions.

3. Behavior management – techniques taught to help the person control their behavior.

Medication

Psychopharmacology is an important component of the plan of therapeutic intervention. A physician prescribes medication after careful review of symptoms and physical health status. Often other types of interventions are not effective until the medication begins to take effect by reaching therapeutic levels. As symptoms subside, the person is better able to become rational and logical in his/her thinking processes.

Individuals who are incarcerated need to continue their medication regime. Arrangements should be made to continue prescribed medications; this may entail delivering prescriptions to the jail. Remember to obtain copies of the prescription(s) and/or physician's orders in order to have the medication dispensed. Individuals who are in jail and do not take their medication will experience an increase in symptoms and, possibly, a corresponding increase of acting out behaviors.

Medication Issues

1. It is important to take medication at the times it is prescribed. Some individuals are most cooperative with taking medications which make them sleepy or tired during the late afternoon or at night. If the individual appears to be lethargic or excessively sleepy counsel may communicate concerns about possible over-medication to the treatment team.

2. Older drugs can have multiple, serious side effects and may not be as effective as new generation psychotropic medications. Haldol and Thorazine are examples of older generation drugs. These medications tend to be less expensive for the consumer since there are generic alternatives available. Some side effects, extrapyramidal symptoms (EPS), can be improved or reversed. Medication monitoring and adjustments are important to avoid irreversible side effects, such as tardive dyskinesia.

3. If a person's behavior seems abnormal and the individual has been arrested for public intoxication or for being a public nuisance, it may not be a substance abuse problem, but rather, a medication issue. Some individuals make attempts at self-medication through drugs and/or alcohol. Individuals who are homeless may find self-medicating an easier alternative than making clinic appointments. Because of the side effects of prescription medications, a self-substitution of alcohol or street drugs may be used to attain desired or more desirable effects. Such individuals should be scheduled for a psychiatric evaluation for medication.

4. Newer generation psychotropic medications have fewer detrimental, irreversible side effects. Some of the newer generation medications include Clozaril, Zyprexa, Risperdal, Seroquel and Geodon. Common side effects include weight loss, weight gain, dry mouth, and irritability. While these drugs are very effective, they are much more expensive and generic alternatives are not available, except for Clozaril.

Outpatient services

Outpatient services are intermittent therapies such as individual, family, group or conjoint counseling. Day service programs, also know as partial hospitalization programs, are a more intensive service option offering an alternative to inpatient treatment.

Outpatient services are appropriate up to the point whereby the person becomes a danger to self or others. (I. C. 12-7-2-53)

Partial Hospitalization Programs

Partial hospitalization programs (PHP), otherwise known as day treatment programs or clubhouse, are designed to help individuals who are in need of long-term care and/or

supports. PHP is typically a structured group program. Activities are provided to develop skills, improve social interactions, and improve in activities of daily living. Individuals learn how to lead a more productive life while dealing with the symptoms of their mental illness.

Assertive Community Treatment

Assertive Community Treatment (ACT) is designed to help the person in their own home, or other choice of living environment. These services are usually provided through the local community mental health centers via a team approach. The intent is to wrap any needed services around the individual i.e. medication management, budgeting, resource acquisition, counseling, skill development, etc.

Intensive Outpatient Programs

Intensive Outpatient programs are designed to address issues related to substance related disorders. This is a psychoeducational model using teaching, counseling and confrontation in a therapeutic milieu.

Inpatient services

Inpatient services are very brief hospitalizations in a psychiatric inpatient unit. The hospitalization is only for relief of a dangerous situation and/or for reduction of gross symptoms. There are specific criteria for a psychiatric inpatient stay. There is limited reimbursement from insurance companies, Medicaid and Medicare for this expensive treatment option.

Without a payer source, a community hospital does not have to honor a court order for treatment. Furthermore, a community hospital does not have to honor a court order if the individual does not meet admission criteria. Under I.C. 12-26-11-2 the superintendent of a state facility may decline to admit the individual if the superintendent determines that adequate space, treatment staff, or treatment facilities appropriate to the needs of the individual are not available.

State Hospital Care

Access to the State of Indiana's psychiatric hospitals is gained through a community mental health center. The community mental health centers (CMHCs) are the gatekeeper for admission. Under I.C. 12-26-6-8, if an individual has been ordered committed to a state institution administered by the Indiana Division of Mental Health and Addiction, then a CMHC must have evaluated the individual and determined that the placement is appropriate. Admissions are strictly controlled through a state hospital bed allocation system. Each CMHC has a limited number of state hospital beds to which they have access for admission.

CMHCs have a variety of initiatives in place and a number under development as alternatives to state hospital care. These initiatives, based in psychosocial rehabilitation models, can be just as effective as hospitalization in a state facility. In some cases, these alternatives may be more effective by maintaining the individuals in their home communities.

Chapter

8

MEDICATION

Psychotropic medications are those prescribed to stabilize or improve one's mood, mental status or behavior.

Newer psychiatric medications have been developed after research on the interaction of chemicals in the nervous system. The nervous system is similar to a series of sparks called synapses. For every body activity, a synaptic spark releases chemicals along nerve paths. Neurotransmitters, such as serotonin, are either changed, depleted or returned from the receptor. Psychiatric medications have the potential to alter the concentration of serotonin of particular types of receptors, thus the term selective serotonin reuptake inhibitor (SSRI).

Older psychiatric drugs primarily target neurotransmitters, other than serotonin, such as norepinephrine. All medications have both positive and negative side effects. Each must be evaluated when determining therapeutic benefit.

It may take 2 to 6 weeks to assess the full therapeutic benefit of an introduced medication or a medication adjustment.

Medication formularies have been developed by Medicaid and insurance companies as a system for cost containment. Third party payers have identified medications they will pay for and the level of reimbursement based upon the frequency of use, efficacy of drug, popularity and generic availability. Such formularies may prevent or discourage individuals from the most effective drugs for that person. Counsel may want to request that the individual's treatment team assess whether the person is receiving the best medication for their condition.

Positive Effects

Positive effects are those that reduce the psychiatric symptom(s) which then allows the person to function at a more optimal level. Positive effects include:

1. Reduction of symptoms;
2. Relief of nervousness;
3. Improved sleep; and/or,
4. Reduction of tremors.

Negative Effects

Negative effects are those bothersome consequences which have a negative impact on the person. To counteract these effects, the person may have to take additional medication, change their eating habits, and/or change activity patterns. Common negative effects include:

1. Dry mouth;
2. Weight gain, weight loss;
3. Photosensitivity;
4. Tardive dyskinesia;
5. Seizures;
6. Anxiety; and/or
7. Impaired memory.

Antipsychotic medication and dopamine –blocking drugs must be monitored for tardive dyskinesia on a regular and systematic basis using a standardized assessment instrument. There are a variety of assessment instruments available. Results should be compared to the baseline measure. When administered at regular intervals, the progression of symptoms can be tracked and necessary adjustments made to the medication regime.

Types of Medications

Antipsychotic Medications

These medications are designed to stabilize the symptoms of psychosis such as hallucinations, delusions and confused thinking. It may take longer for medication to reach a therapeutic effect for persons who have not been medicated previously. However, you may see an immediate relief of symptoms with a change of medication for those who have already been prescribed antipsychotics. If an individual takes oral medication, a reduction in symptoms may become evident as early as 2-3 days after initiation. A longer period of time is necessary to reach a therapeutic level. Clozaril, Risperdal, Seroquel, Geodon and Zyprexa are examples of antipsychotic medications.

Antidepressants

These medications are developed to alleviate the symptoms of depression by correcting the chemical imbalance of the brain thereby reducing the effects of the depression. It may take 4-6 weeks for antidepressants to reach a full therapeutic level; however, relief may be achieved much sooner. Antidepressants are not addictive. Prozac, Zoloft, Wellbutrin, Paxil, Effexer, Elavil and Celexa are examples of antidepressant medications.

Antianxiety Medications

These medications affect the central nervous system to relieve or reduce anxiety. Antianxiety medications are quick acting and are often used as a PRN to bring rapid relief of symptoms. Antianxiety drugs can be abused and can lead to dependence. Buspar, Ativan, Valium, Xanax, Klonopin and Atarax are examples of antianxiety medications.

Chapter

9

COMMUNICATION TECHNIQUES

Respect, dignity and common courtesies are paramount for effective communication.

Therapeutic communication

Therapeutic communication is the process whereby you and your client have a meaningful conversation directed at the reason why s/he is being represented by a public defender. The conversation should be goal-directed and concise so that the person can understand and know the expectations.

The therapeutic communication should result in a plan to address the situation, improve it and/or otherwise remedy it. If you are unable to reach an agreeable plan, it is then important to identify why not.

There are 7 general principles to remember when talking to a person with a mental illness, or anyone who may have cognitive deficits.

1. Respect the person's limits and their personal body space.
2. Use open-ended questions, using positive statements, rather than those requiring yes or no answers.
3. Use a calm, quiet, even-toned voice (even when you do not feel like it).
4. Promote involvement by providing the person recommendations, choices, options and possible solution(s).
5. Maintain your personal body space. Do not crowd the person. Situate yourself at eye level with the person.
6. Use phrases to show respect and to provide positive reinforcement. Overemphasize the common courtesies such as please, thank-you, may I, excuse me.
7. Do not talk down to the person.

Therapeutic techniques

There are a variety of techniques one can use to assure that therapeutic communication occurs. It is important to use techniques which will prevent or minimize an individual from becoming agitated. Many techniques are situational and may work one time, but not the next. Remember to ground your discussions in the 7 general principles listed above.

Use phrases showing respect to provide positive reinforcement. Use please, thank-you, may I, excuse me – profusely.

Use a calm voice when talking to your client. Use short, concrete statements and make eye contact.

Have discussions in a quiet room to reduce stimulation; avoid intrusive environments with multiple things going on. Ringing telephones and radios can interfere with the person's ability to concentrate.

Moderate the context of your discussions. Avoid using sarcasm or teasing the person which may be misunderstand or misperceived. Also, avoid analogies such a "a bird in the hand is worth 2 in the bush". The individual may interpret your analogy very differently than you intended.

Avoid arguing with the person. If the person is upset, ask her to sit down and explain to you what she needs. When a person sits down, she will usually calm down. Stay beyond the person's arm reach.

Use written materials. First, assess if the individual can read and write. Even if the person can not, the use of written materials gives one something to focus upon during your discussion. The use of verbal and written communication helps to reinforce your message.

If you are having difficulty communicating with the individual, have another person present. Preferably, this would be someone who knows the client well. The other person could rephrase your statements using different words to explain things to the client. Please note any implications to client privilege.

Ask client to repeat statements to confirm clarity and understanding.

Use redirection. It is an effective technique to de-escalate an individual or to cease the person's tangential ramblings. One may redirect by changing the subject, focusing on positive aspects rather than negative ones, or asking a totally unrelated question before returning to a sensitive topic.

Interview techniques

Introduce yourself by using your first and last name.

Let the person know you have to ask many questions. Let the person know that their answers are important to you and you will be writing down the answers.

Ask the person to tell you when he needs a break.

Ask open-ended questions like, “Tell me what happened”, “Could you explain to me_____?” “Tell me what you were thinking when _____”

However, if after asking a few questions, the person tends to ramble endlessly, you may need to put more structure to the questions and ask more close-ended questions.

If you know the individual suffers from hallucinations or delusions, ask if voices were heard at the time of the incident or before the incident. Ask what the voices were saying.

When you have several confrontive or intrusive questions to ask, minimize eye contact.

Have a box of tissues available. Individuals suffering from depression may become very tearful.

When questioning individuals who do get tearful, it may be helpful to give him/her a pat on the hand to be encouraging and to keep them talking.

Managing anger

If a person appears to begin getting agitated or angry, encourage them to stop, take a deep breath and perhaps take a break. A cigarette break or a walk to the drinking fountain may serve as a calming agent.

Do not let the anger escalate. The public defender should use a calm soft voice.

Recognize the physical clues, see if the person acts like s/he is getting hot by pulling at the collar, face turns red, you observe facial grimacing, and/or clenched fists.

If the person denies knowing what triggers anger outbursts, ask the person to tell you about what he was thinking when he was angry.

Chapter

10

LEGAL CHALLENGES

Obstacles

There will be obstacles facing the public defender who is representing the client with a mental illness. It is important to remember that this is an anxiety-producing situation and therefore, the person's behavior may not be predictable. Following these tips, you should be able to minimize difficulties in communicating with the individual.

The individual may not be a reliable informant. The person may not be able to remember details when under stress or when pressed for answers. Providing the person with paper and pencil to make their own notes before and after your meetings will help them to remember.

The family may not be dependable. The family may feel guilty about getting the person "in trouble." Family members may be reluctant to appear in court. They may be afraid of the individual.

Information, which you may need, is privileged, confidential mental health records. Specific consents for release are required.

As the public defender talks to the client, it is not only important to make sure that the client knows what the charges are and what to expect while in court, but it will also be important to determine if the client is competent to stand trial. (I.C. 35-36-3) The public defender will need to assess whether the individual is competent to stand trial at the present time and determine if the client knew what he or she was doing at the time of the event. During the interview process, the public defender will need to assess whether the individual's mental illness will interfere with the client's understanding of the legal process and their ability to defend themselves. The public defender should focus heavily on the individual's state of mind at the time of the events leading up to the arrest. Ascertain what the client was thinking or experiencing at that time. The public defender can also consider requesting that the individual's treatment make a determination as to the individual's competency to participate in the legal proceedings. This information may lead to plea bargaining or an insanity defense plea. The public defender should also familiarize him/herself with various community resources and mental health facilities that can be identified as options as a part of the plea bargaining/sentencing as opposed to consideration only being given to incarceration or probation/parole.

Refer to I.C. 35-35 and 36 on Pleading and Procedure and Pretrial Notices, Motions, and Procedures.

An individual with a mental illness can not be adequately represented by having brief telephone contacts or quick meetings with his/her public defender.

Mental Health Commitments

An individual who is mentally ill and either dangerous or gravely disabled may be involuntarily detained or committed under four statutes in Indiana.

Indiana Code Citations

- I.C. 12-26-4 outlines an immediate detention (ID). A law enforcement officer who has reasonable grounds to believe that an individual is mentally ill, dangerous and in immediate need of hospitalization and treatment has the authority to apprehend and transport a person to the nearest appropriate treatment facility. The officer must provide a written statement to the facility containing the reason(s) for the officer's decision to transport the person. The individual may be held for up to 24 hours (also known as a "24 hour hold"), unless the facility or physician files an application for an emergency detention. The person may also be charged with an offense, if appropriate.

- I.C. 12-26-5 outlines an emergency detention (ED). A petition stating the applicant's belief that the person is mentally ill, dangerous and in immediate need of restraint must be filed with the court. This statement must be supported by a physician's statement that, based on either examination of the individual or information provided to the physician, the physician believes that the patient may be mentally ill and dangerous. A judge must approve the application and subsequently issue a warrant for the person's arrest. An individual may then be detained in a mental health facility for up to 72 hours (also known as a "72 hour hold"). Before the end of the 72-hour detention period, the facility or doctor must submit a written report of the person's examination. The report must state that the person either does or does not have a mental illness that renders him/her dangerous or gravely disabled and requiring continuing treatment. If the person does not require continuing treatment, s/he shall be discharged. If the individual does require continuing treatment, a hearing must then be held to determine if continued detention is appropriate.

- I.C. 12-26-6 outlines a temporary commitment. An individual who is believed to be mentally ill and dangerous to self or others, or gravely disabled, may be committed for a period of not more than 90 days. Typically, a petition is filed with the court and supported by a physician's written statement that the physician has examined the person within the past 30 days and the doctor believes that the person is mentally ill, either dangerous to self or others or gravely disabled, and in need of custody, care or treatment in an appropriate facility. The court will schedule a hearing at which time evidence is heard as to whether the person is indeed mentally ill,

dangerous and/or gravely disabled and in need of treatment. If the court finds, after consideration of the record and completion of the hearing, that the person is mentally ill and either dangerous or gravely disabled, the court may order an individual to be committed to a facility or to enter an outpatient treatment program for not more than 90 days. It is expected that the person would be discharged within 90 days. If, in the opinion of the physician, the person requires continuing treatment, a report must be filed to the court making such a recommendation. Another court hearing is held to determine if continued treatment is needed. The commitment may be extended for an additional 90 days; if continued treatment is necessary at the end of the second 90 days, a petition for regular commitment must be filed with the court.

- I.C. 12-26-7 outlines a regular commitment for persons who are in need of treatment exceeding 90 days. This type of proceeding is initiated by filing a petition, including a physician's written statement. A hearing is held in the same manner as for a temporary commitment. A regular commitment is open-ended and does not terminate until the facility discharges the person or the court orders a termination of the commitment or a release from the therapy program. An annual report to the court must be filed which reports the person's condition and treatment plan. An individual under a regular commitment may request a hearing once a year.

Preparation for Hearing

To prepare an individual for a commitment proceeding, have someone familiar with the person give verbal notice that a commitment hearing will be held. Document the discussion in the medical record. A summons from the court will be sent to the person, too.

If the individual for whom a commitment is being sought is already in the facility, the facility may transport the person to court. An appropriate staff person should also accompany the individual. Many courts require that the person arrive before the scheduled hearing time in order to meet with the court-appointed attorney. The medical record, or a copy, may be made available to the court-appointed attorney before the hearing.

Typically, an order is issued immediately after the conclusion of the commitment hearing. It is helpful if the court-appointed attorney and facility representative both get copies and reiterate the decision and recommendations of the court to the individual.

An involuntarily committed patient may challenge a treatment they wish to refuse by filing a petition with the committing court. Annually, the individual may request a review hearing.

For re-commitment proceedings, individuals are often transported from a state operated facility back to the county in which the initial commitment order was issued.
Because this transportation is often provided by the county sheriff's office, such individuals are frequently "housed" in the county jail to await the hearing or transport back to the state operated facility, even though most of such persons have no criminal charges pending. Public

defenders should consider strenuously objecting to this practice as it represents a major violation of the individual's rights.

Informed Consent

Written, informed consent must be obtained from the client before disclosure of any confidential information. Information should be presented orally, in writing and in the terms and in a manner the individual understands.

Information presented to the individual regarding informed consent for treatment includes:

1. a diagnosis or specific signs or symptoms to be changed and how each will be monitored;

2. a description of proposed treatment, anticipated therapeutic benefits and length of treatment and the expected duration;

3. reasonable alternatives to treatment;

4. possible risks and side effects; and,

5. specific information about medication prescribed, including dose, dosage range, route of administration.

Case Scenario

John Doe is a 36 year old male. Mr. Doe was recently arrested for breaking and entering. He was very agitated and verbally aggressive with the arresting police officers. His thoughts were very confused, he was rambling and quoting biblical verses. It was extremely difficult for the police to communicate with Mr. Doe and he did not appear to understand what the officers were saying. Mr. Doe talked incessantly about needing to save the woman inside the home and protecting her from the evil spirits. While incarcerated, Mr. Doe became very agitated and began yelling for his meds. Upon inquiry, jail staff discovered that Mr. Doe is receiving mental health services from the local community mental health center and has been diagnosed with paranoid schizophrenia.

The day after his arrest, Mr. Doe was scheduled to meet with the public defender, Ms. Jones, who had been assigned to his case. Ms. Jones met with Mr. Doe in a quiet room, introduced herself, and explained to Mr. Doe what her job is. Ms. Jones asked Mr. Doe to sit down and began to ask him some very general questions in order to get to know him. She also allowed him to ask her some questions so that he could get to know her. Initially, Mr. Doe was very fearful and agitated and appeared to be very preoccupied with something in the room. It was very difficult for him to stay focused on what Ms. Jones was telling him. Ms. Jones was becoming very frustrated but recalled what was written in the arrest report and began to ask Mr. Doe some open ended questions about how he was feeling. She then proceeded to ask him if he were hearing voices and what these voices were telling him. Ms. Jones remained calm and did not rush her client and eventually learned that he was experiencing auditory

hallucinations at the time that the crime was committed. In fact, Mr. Doe explained that the voices were telling him to help the elderly woman who lived next door by saving her from the evil spirits. Mr. Doe also informed Ms. Jones that he let his family borrow some money from him and he was unable to pay for his medication so he had not taken any of his antipsychotic medication for over two weeks.

Although Mr. Doe admitted that he did indeed break into the neighbors house, the public defender was able to explain to the judge how his psychiatric disorder had effected his behavior, and asked that he be placed on diversion, where psychiatric treatment and medication compliance would be mandatory under this agreement.

Ms. Jones used the following guidelines in preparing her client for court. This seemed to be extremely helpful for both the client and public defender in reducing frustration and the amount of time spent in the legal system.

Preparing a Consumer for Court

Preparation for court will familiarize the person with the proceedings and the setting. This serves to reduce fears and anxiety from being in unfamiliar places and in unfamiliar roles.

1. Introduce yourself to the person and give a short explanation of your role. Be certain the individual understands you are working for him/her, and that information shared with you is considered confidential as under the rules of attorney-client privilege.

2. Have your meeting, whenever possible, in a quiet environment with as few distractions as possible.

3. Go through legal papers which have been filed and served upon the individual and explain what these documents mean.

4. Discuss with the client what role he or she will need to play in any upcoming proceedings. If the client will need to be a witness, give the client examples of the questions that will be asked and practice having the client answer the questions.

5. Describe in detail the room where the hearing may be held. Will the client need to go to the front and sit on the witness stand, or will she be permitted to stay seated next to you? Describe where the judge and court reporter will be located and explain their roles. Do the same for other parties and witnesses who will also be present.

6. If you discover the client becomes agitated easily or is likely to be compromised by anxiety issues related to testifying, or even appearing in court, it is your duty to contact the treating staff and discuss the impact of the hearing on the client's well-being. Treatment clinicians may suggest coping skills for the stressful situation and/or review the proceedings with the client. Also, advise the Court regarding such special issues or needs. There may be ways to minimize the

"formal" atmosphere of the courtroom by holding the hearing in a smaller hearing room, or even having the client appear by telephone, etc.

7. To the extent possible, do not to make or encourage disparaging remarks about the treating physicians or treatment team/facility. If, for example, you are representing your client in a commitment proceeding and the commitment is granted, the treating clinicians are the people who will be working to help the client improve functioning level and condition. It is to the client's benefit to know that the treatment team/facility are not the "bad guys."

8. Prepare your client for the type of testimony that is going to be required of other witnesses. If the treating doctor will be required to present examples of the client's "bad" behavior, or to say he or she is "dangerous" or "gravely disabled", let your client know why those words may be chosen (pursuant to the Indiana statutes) and to reiterate that the physician is under oath to tell the truth as he believes it.

   The same is true of others, like family members who may be testifying. They are presumably trying to do what is in the best interest of the client, although it may be interpreted by the client as someone is "out to get them."

9. After court, meet with client, review the proceedings, and discuss next steps. Find out what remaining question the individual may have regarding the proceedings. Plan the next step.

Chapter

11

RESOURCES

Resources and informational materials are included with this training manual to supplement the content and provide the reader a next step in understanding the study of psychiatry. Recommended websites are listed. Caution should be used when searching for reliable information from the internet. Nationally recognized organizations and university-affiliated programs are the most credible sources of information from the internet.

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Chapter 3 Reference Materials

Working with Psychiatric Clients

Types of Crises

General Principles

- Focus on the client's actions rather than words.
- Don't overlook cognitive deficits.
- Promote independence (involve in treatment decisions).
- Be encouraging.
- Regulate tone and rhythm of voice, use eye contact and short simple statements.
- Repeat instructions.
- Respect the person's limits.
- Set timetable for the long haul.
- Be systematic in your work.
- Staff need outside activities and friendships.

Maladaptive Behavior

Maladaptive behavior can be defined as any overt pattern of action, which is:

1) An inappropriate and persistent response to internal or external stimuli;

2) Detrimental to the individual or others; and/or

3) Rigidly maintained.

Functions of Maladaptive Behavior

Maladaptive behavior effects the person's abilities in the following areas:

- Communication;
- Control of social milieu;
- Modulation of mood states;
- Modulation of pain; and/or
- Modulation of other behavior

Environmental Aids

The following strategies will assist the individual in his/her environment:

- Simplify the environment;
- Structure the environment;
- Establish a routine;
- Structure a balance of activities; or
- Assist with basic needs, if required,

Redirection

The following are suggestions on how to redirect individuals:

- Do not engage in power struggles;
- use activities that they like to divert their attention;
- Do not argue with them, but ask them to join you in a task;
- Move them away from the source of tension;
- If you are unable to redirect the individual away from the source of friction, remove the source;
- Offer the individual a cigarette, pop, etc. and take them for a walk (they may begin to talk about what is bothering them);
- Offer to turn on a movie that they enjoy watching;
- Play a game;
- Have the individual fix a snack or assist staff with this task; and/or
- Have the individual take a nap or shower.

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TYPES OF CRISES

Crisis is generally associated with some form of violence:

- Physical Aggression
- Verbal Aggression
- Self-injurious Behavior (and Suicide)
- Hostage Taking
- Property Destruction
- Criminal Acts
- Sexual Aggression
- Being Harmed by Others

Crisis may include some non-violent situations, such as:

- Psychiatric decompensation
- Elopement
- Non-compliance
- Illness and Health Problems
- Loss and Grief
- Barricaded Person
- Refusal of Medications
- Agitation (or Other Behavior) that is Disruptive

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Chapter 9 Reference Materials

***COMMON ROOT CAUSES** Of Behavioral Outbursts*

COMMON ROOT CAUSES

Of Behavioral Outbursts

Four Basic Assumptions About Any Behavior:

Behavior has a purpose;

Behavior communicates;

Behavior is connected; and,

One behavior may serve multiple needs.

- Idleness and Boredom
- Communication Frustration
- Sexual Drive
- Health, Medical, or Physical Issues (especially those involving pain or discomfort) Medication Side-effects
- Sensory (Hyper-or Hypo-Stimulability)
- Attention-seeking (Self-esteem-Acceptance)
- Escape (Avoidance, Fear, Refusal)
- Disturbed thought patterns
- To control or manipulate one's environment

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Chapter 10 Reference Materials

Preparing for the Mental Health Consultation

I.C. 12-7-2-38

I.C. 12-7-2-53

I.C. 12-26-1

I.C. 12-26-2

I.C. 12-26-3

I.C. 12-26-4

I.C. 12-26-5

I.C. 12-26-6

I.C. 12-26-7

I.C. 35-35-1

I.C. 35-36-2

I.C. 35-36-3

PREPARING FOR A MENTAL HEALTH CONSULATION

As much of the following information as possible should be collected for any client being referred for a mental health consultation.

(1) Reason for referral
(2) Duration of problem
Estimate the length of time that the problem has been present.
(3) Presence of precipitants
Describe any significant emotional or physical events which directly preceded the onset of the behavioral problem.
(4) Functioning level
List current mental age and social age.
List most recent psychological test results.
Record cause of mental retardation, if know.
(5) Psychosocial status
Record current living and social arrangements, educational, vocational, and recreational program in which the client participates.
(6) Name of primary contact person
(7) Current medical problems
List diagnosis and those physicians/clinics where the client is being treated.
(8) Current drug therapy
For each prescribed drug, list the name, dosage, administration schedule, and Prescribing physician.
(9) Previous mental health interventions
List dates of treatment, type of problem, and the name of the treating clinician or mental health agency.
(10) Family history of mental illness
for each family with a history of mental illness, describe type of problem, treatment dates, and the name of the treating clinician or mental health agency.
(11) Changes in vegetative functioning and behavior
-engery level: …. increased…. decreased…. unchanged
-appetite: …. increased…. decreased…. unchanged
-weight change:….losing ….gaining ….unchanged
If there has been a change in weight, record amount of weight lost or gained, and length of time during which it occurred.
-sleep pattern: ….has difficulty falling asleep
….awakens during the night
….awakends too early in the morning
….has an increased need for sleep
-urinary incontinence: ….no ….yes
if yes, is behavior new: ….no ….yes
-fecal incontinence: ….no ….yes
if yes, is behavior new: ….no …yes

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IC 12-7-2-38

Sec. 38. "Community mental health center" means a program of services that meets the following conditions:

(1) Is approved by the division of mental health and addiction.
(2) Is organized for the purpose of providing multiple services for persons with mental illness or a chronic addictive disorder.
(3) Is operated by one (1) of the following or any combination of the following:
(A) A city, a town, a county, or another political subdivision of Indiana.
(B) An agency of the state.
(C) An agency of the United States.
(D) A political subdivision of another state.
(E) A hospital owned or operated by a unit of government described in clauses (A) through (D).
(F) A building authority organized for the purpose of constructing facilities to be leased to units of government.
(G) A corporation incorporated under IC 23-7-1.1 (before its repeal August 1, 1991) or IC 23-17.
(H) A nonprofit corporation incorporated in another state.
(I) A university or college.
As added by P.L.2-1992, SEC.1. Amended by P.L.23-1993, SEC.35; P.L.40-1994, SEC.9; P.L.215-2001, SEC.24.

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IC 12-7-2-53

Sec. 53. "Dangerous", for purposes of IC 12-26, means a condition in which an individual as a result of mental illness, presents a substantial risk that the individual will harm the individual or others.
As added by P.L.2-1992, SEC.1.

IC 12-26-1
Chapter 1. Jurisdiction and Procedure

IC 12-26-1-1
Sec. 1. An individual who is mentally ill and either dangerous or gravely disabled may be involuntarily detained or committed under any of the following statutes:
(1) IC 12-26-4 (immediate detention).
(2) IC 12-26-5 (emergency detention).
(3) IC 12-26-6 (temporary commitment).
(4) IC 12-26-7 (regular commitment).
As added by P.L.2-1992, SEC.20.

IC 12-26-1-2
Sec. 2. Except as provided in sections 3 and 4 of this chapter, the following Indiana courts have jurisdiction over a proceeding under this article:
(1) A court having probate jurisdiction.
(2) A superior court in a county in which the circuit court has exclusive probate jurisdiction.
(3) A mental health division of a superior court to the extent the mental health division has jurisdiction under IC 33-5.1-2-4.
As added by P.L.2-1992, SEC.20. Amended by P.L.16-1995, SEC.4.

IC 12-26-1-3
Sec. 3. A court that conducted the trial has jurisdiction over a hearing required to be held by IC 35-36-2-4. The court retains jurisdiction over the individual held under IC 35-36-2-4 until the completion of the commitment hearing. After completion of the commitment hearing, jurisdiction is transferred to a court having jurisdiction under section 2 of this chapter and all subsequent petitions or motions shall be filed with the court to which the proceeding is transferred. The file of the commitment hearing also shall be transferred from the committing court to the court having probate jurisdiction.
As added by P.L.2-1992, SEC.20.

IC 12-26-1-4
Sec. 4. (a) A juvenile court has concurrent jurisdiction over proceedings under this article that involve a child.
(b) The juvenile court may not commit or temporarily place a child under this article in a facility other than a child caring institution. If the juvenile court determines that commitment or temporary placement of a child in another facility is necessary, the juvenile court shall transfer the proceeding to a court having probate jurisdiction.
As added by P.L.2-1992, SEC.20.

IC 12-26-1-5
Sec. 5. (a) If a commitment proceeding is begun under IC 12-26-3-5, IC 12-26-6-2(a)(1), or IC 12-26-6-2(a)(3), the court acquires jurisdiction over the alleged mentally ill individual by service of summons on the individual according to the Indiana Rules of Trial Procedure or by entry of an appearance by the individual.
(b) If an individual is being held under IC 12-26-6-2(a)(2), the court retains jurisdiction over the individual by the court's order for continued detention.
As added by P.L.2-1992, SEC.20.

IC 12-26-1-6
Sec. 6. Except as otherwise provided, a judicial proceeding under this article shall be conducted as other civil proceedings according to the Indiana Rules of Trial Procedure.
As added by P.L.2-1992, SEC.20.

IC 12-26-1-7
Sec. 7. (a) This section does not apply in the following statutes:
(1) IC 12-26-4.
(2) IC 12-26-11.
(3) IC 12-26-12.
(b) This section does not apply to computation of a period during which an individual may

be detained under this article.
(c) In computing time under this article, Saturdays, Sundays, and legal holidays are not included in the computation if the time prescribed is less than fourteen (14) days.
As added by P.L.2-1992, SEC.20.

IC 12-26-1-8

Sec. 8. Upon the filing of a petition for commitment under IC 12-26-6 or IC 12-26-7 or the filing of a report under IC 12-26-3-5, the individual may be detained in an appropriate facility:
(1) by an order of the court pending a hearing; or
(2) pending an order of the court under:
(A) IC 12-26-3-6;
(B) IC 12-26-5-10; or
(C) IC 12-26-5-11.
As added by P.L.2-1992, SEC.20.

IC 12-26-1-9

Sec. 9. (a) In a proceeding involving involuntary detention or commitment under this article, appeals from the final orders or judgments of the court of original jurisdiction may be taken by any of the following:
(1) The individual who is the subject of the proceeding.
(2) A petitioner in the proceeding.
(3) An aggrieved person.
(b) An appeal must be taken in the same manner as any other civil case according to the Indiana Rules of Trial and Appellate Procedure.
As added by P.L.2-1992, SEC.20.

IC 12-26-1-10

Sec. 10. Each division shall adopt rules under IC 4-22-2 to administer this article.
As added by P.L.2-1992, SEC.20.

IC 12-26-1-11

Sec. 11. Each division shall prescribe the forms that must be used to administer this article.
As added by P.L.2-1992, SEC.20.

IC 12-26-2

Chapter 2. Rights of Persons

IC 12-26-2-1

Sec. 1. This article does not limit or restrict the right of a person to apply to an appropriate court for a writ of habeas corpus.

As added by P.L.2-1992, SEC.20.

IC 12-26-2-2

Sec. 2. (a) This section applies under the following statutes:

(1) IC 12-26-6.

(2) IC 12-26-7.

(3) IC 12-26-12.

(4) IC 12-26-15.

(b) The individual alleged to be mentally ill has the following rights:

(1) To receive adequate notice of a hearing so that the individual or the individual's attorney can prepare for the hearing.

(2) To receive a copy of a petition or an order relating to the individual.

(3) To be present at a hearing relating to the individual. The individual's right under this subdivision is subject to the court's right to do the following:

(A) Remove the individual if the individual is disruptive to the proceedings.

(B) Waive the individual's presence at a hearing if the individual's presence would be injurious to the individual's mental health or well-being.

(4) To be represented by counsel.

As added by P.L.2-1992, SEC.20.

IC 12-26-2-3

Sec. 3. (a) This section applies under the following statutes:

(1) IC 12-26-6.

(2) IC 12-26-7.

(3) IC 12-26-12.

(4) IC 12-26-15.

(b) The individual alleged to be mentally ill, each petitioner, and all other interested individuals shall be given an opportunity to appear at hearings and to testify.

(c) The individual alleged to be mentally ill and each petitioner may present and cross-examine witnesses at hearings.

(d) The court may receive the testimony of any individual.

As added by P.L.2-1992, SEC.20.

IC 12-26-2-4

YAMD.1992

Sec. 4. (a) This section applies under the following statutes:

(1) IC 12-26-6.

(2) IC 12-26-7.

(3) IC 12-26-12.

---

(4) IC 12-26-15.

(b) The individual alleged to be mentally ill and a petitioner:

(1) has a right to a change of judge; and

(2) is not entitled to a change of venue from the county.

As added by P.L.2-1992, SEC.20.

IC 12-26-2-5

Sec. 5. (a) This section applies under the following statutes:

(1) IC 12-26-6.

(2) IC 12-26-7.

(3) IC 12-26-12.

(4) IC 12-26-15.

(b) A petitioner may be represented by counsel.
(c) The court may appoint counsel for a petitioner upon a showing of the petitioner's indigency and the court shall pay for such counsel if appointed.
(d) A petitioner, including a petitioner who is a health care provider under IC 16-18-2-295(a), in the petitioner's individual capacity or as a corporation is not required to be represented by counsel. If a petitioner who is a corporation elects not to be represented by counsel, the individual representing the corporation at the commitment hearing must present the court with written authorization from:
(1) an officer;
(2) a director;
(3) a principal; or
(4) a manager;
of the corporation that authorizes the individual to represent the interest of the corporation in the proceedings.
(e) The petitioner is required to prove by clear and convincing evidence that:
(1) the individual is mentally ill and either dangerous or gravely disabled; and
(2) detention or commitment of that individual is appropriate.
As added by P.L.2-1992, SEC.20. Amended by P.L.1-1993, SEC.152; P.L.2-1995, SEC.60; P.L.6-1995, SEC.21; P.L.256-1999, SEC.2; P.L.14-2000, SEC.33.

IC 12-26-2-6

Sec. 6. (a) A person who without malice, bad faith, or negligence acts according to this article and:
(1) participates in proceedings for the detention or commitment of an individual; or
(2) assists in the detention, care, and treatment of an individual alleged or adjudged to be mentally ill;
is immune from any civil or criminal liability that might otherwise be imposed as a result of the person's actions.
(b) The immunity provided by this section does not permit a person to do either of the following:
(1) Physically abuse an individual.
(2) Deprive an individual of a personal or civil right except according to this article.

As added by P.L.2-1992, SEC.20.

IC 12-26-2-7

Sec. 7. Except for gross misconduct, if a child's advocate performs the advocate's duties in good faith, the advocate is immune from any civil liability that may occur as a result of the advocate's performance of duties.
As added by P.L.2-1992, SEC.20.

IC 12-26-2-8

Sec. 8. (a) Detention or commitment of an individual under this article does not deprive the individual of any of the following:
(1) The right to do the following:
(A) Dispose of property.
(B) Execute instruments.
(C) Make purchases.
(D) Enter into contracts.
(E) Give testimony in a court of law.
(F) Vote.
(2) A right of a citizen not listed in subdivision (1).
(b) A procedure is not required for restoration of rights of citizenship of an individual detained or committed under this article.
As added by P.L.2-1992, SEC.20.

IC 12-26-2-9

Sec. 9. (a) The superintendent of a state institution may decline to admit an individual if the superintendent determines that there is not available adequate space, treatment staff, and

treatment services appropriate to the needs of the individual.
(b) If an individual is refused admission under subsection (a), the commitment shall be transferred to the appropriate division. The division shall make arrangements for the individual's admission to an appropriate facility.
As added by P.L.2-1992, SEC.20. Amended by P.L.6-1995, SEC.22.

IC 12-26-3

Chapter 3. Voluntary Treatment

IC 12-26-3-1

Sec. 1. The superintendent of a facility or an individual's attending physician may admit an Indiana resident who:

(1) is mentally ill or has symptoms of mental illness; and

(2) makes an appropriate application;

for observation, diagnosis, care, or treatment.

As added by P.L.2-1992, SEC.20.

IC 12-26-3-2

Sec. 2. (a) If an individual is less than eighteen (18) years of age, an application under this chapter may be made by the individual's parent or legal guardian.

(b) If an individual is at least eighteen (18) years of age and has a legal guardian, that individual may not be admitted by the individual's legal guardian to a state institution under this chapter.

As added by P.L.2-1992, SEC.20. Amended by P.L.6-1995, SEC.23.

IC 12-26-3-3

Sec. 3. The superintendent or an individual's attending physician may discharge an individual admitted under this chapter if the superintendent or the attending physician determines that:

(1) care in the facility is not necessary; or

(2) the discharge would contribute to the most effective use of the facility for the care and treatment of the mentally ill.

As added by P.L.2-1992, SEC.20.

IC 12-26-3-4

Sec. 4. Except as provided in section 5 of this chapter, an individual who has been admitted to a facility under this chapter shall be released within twenty-four (24) hours of a written request for release made to the superintendent or the individual's attending physician by:

(1) the individual; or

(2) if the individual is less than eighteen (18) years of age, the parent or guardian who applied for the individual's admission to the facility.

As added by P.L.2-1992, SEC.20.

IC 12-26-3-5

Sec. 5. (a) The superintendent or the attending physician is not required to release an individual under section 4 of this chapter if the superintendent or the attending physician has reason to believe the individual is mentally ill and either dangerous or gravely disabled.

(b) If the superintendent or the attending physician makes a determination under subsection (a), the superintendent or the attending physician must make a written report to a court:

(1) that has jurisdiction;

(2) in the county:

(A) of the residence of the individual; or

(B) where the facility is located; and

(3) not later than five (5) days of receiving the request made under section 4 of this chapter.

(c) A report under subsection (b) must:

(1) state that there is probable cause to believe that the individual is mentally ill and either dangerous or gravely disabled;

(2) state that the individual requires continuing care and treatment in the facility; and

(3) request a hearing on the report.
As added by P.L.2-1992, SEC.20.

IC 12-26-3-6

Sec. 6. The court shall, within two (2) days from the date of receiving a report made under section 5 of this chapter, do either of the following:
(1) Set a preliminary hearing to determine if there is probable cause to believe that the individual is:
(A) mentally ill and either dangerous or gravely disabled; and
(B) in need of temporary or regular commitment.
(2) Order a final hearing to be held within two (2) days of the order to determine if the individual is:
(A) mentally ill and either dangerous or gravely disabled; and
(B) in need of temporary or regular commitment.
As added by P.L.2-1992, SEC.20.

IC 12-26-3-7

Sec. 7. (a) A physician's statement may be introduced into evidence at the preliminary hearing without the presence of the physician.
(b) A finding of probable cause may not be entered at the preliminary hearing unless there is oral testimony:
(1) subject to cross-examination;
(2) of at least one (1) witness who:
(A) has personally observed the behavior of the individual; and
(B) will testify as to facts supporting a finding that there is probable cause to believe that the individual is in need of temporary or regular commitment.
(c) If after the preliminary hearing the court does not find probable cause, the individual shall be discharged immediately.
(d) If after the preliminary hearing the court finds probable cause to believe that the individual is in need of temporary or regular commitment, the court shall order the detention of the individual in an appropriate facility pending a final hearing.
As added by P.L.2-1992, SEC.20.

IC 12-26-3-8

Sec. 8. (a) If the court sets a preliminary hearing under section 6(1) of this chapter, a final hearing shall be held not later than ten (10) days after the date of the preliminary hearing.
(b) At the final hearing, an individual may not be found in need of temporary or regular commitment unless at least one (1) physician who
has personally examined the individual testifies at the hearing.
(c) The testimony required by subsection (b) may be waived by the individual if the waiver is voluntarily and knowingly given.
As added by P.L.2-1992, SEC.20.

IC 12-26-3-9

Sec. 9. (a) If an individual has not previously been the subject of a commitment proceeding, the court may only order temporary commitment.
(b) If an individual has previously been the subject of a commitment proceeding, the court may order a regular commitment if a longer period of treatment is warranted.
As added by P.L.2-1992, SEC.20.

IC 12-26-4

Chapter 4. Immediate Detention

IC 12-26-4-1

Sec. 1. A law enforcement officer, having reasonable grounds to believe that an individual is mentally ill, dangerous, and in immediate need of hospitalization and treatment, may do the following:

(1) Apprehend and transport the individual to the nearest appropriate facility. The individual may not be transported to a state institution.

(2) Charge the individual with an offense if applicable.

As added by P.L.2-1992, SEC.20. Amended by P.L.40-1994, SEC.55.

IC 12-26-4-2

Sec. 2. A law enforcement officer who transports an individual to a facility under section 1 of this chapter shall submit to the facility a written statement containing the basis for the officer's conclusion that reasonable grounds exist under this chapter.

As added by P.L.2-1992, SEC.20.

IC 12-26-4-3

Sec. 3. The statement required by section 2 of this chapter shall be filed with both of the following:

(1) The individual's records at the facility.

(2) The appropriate court if action relating to any charges filed by the officer against the individual is pursued.

As added by P.L.2-1992, SEC.20.

IC 12-26-4-4

Sec. 4. The superintendent of the facility or a physician may furnish emergency treatment necessary to preserve the health and safety of the individual detained.

As added by P.L.2-1992, SEC.20.

IC 12-26-4-5

Sec. 5. Except as provided in section 6 of this chapter, an individual may not be detained under this chapter for more than twenty-four (24) hours from the time of admission to the facility.

As added by P.L.2-1992, SEC.20.

IC 12-26-4-6

Sec. 6. If the superintendent or the attending physician believes the individual should be detained for more than twenty-four (24) hours from time of admission to the facility, the superintendent or the physician must have an application filed for emergency detention under IC 12-26-5 immediately upon the earlier of the following:

(1) A judge becomes available.
(2) Within seventy-two (72) hours of admission to the facility.
As added by P.L.2-1992, SEC.20.

IC 12-26-4-7

Sec. 7. An individual detained under this chapter shall be discharged if either the attending physician or superintendent believes detention is no longer necessary.
As added by P.L.2-1992, SEC.20.

IC 12-26-4-8
Sec. 8. A period of detention under this chapter is in addition to a period of detention under IC 12-26-5.
As added by P.L.2-1992, SEC.20.

IC 12-26-5-8

Sec. 8. The court shall consider and act upon a report described in section 7 of this chapter within twenty-four (24) hours of receiving the report.
As added by P.L.2-1992, SEC.20.

IC 12-26-5-9

Sec. 9. (a) After receiving a report described in section 7 of this chapter, the court may do any of the following:

(1) Order the individual released.

(2) Order the individual's continued detention pending a preliminary hearing. The purpose of a hearing under this subdivision is to determine if there is probable cause to believe that the individual is:

(A) mentally ill and either dangerous or gravely disabled; and

(B) in need of temporary or regular commitment.

(3) Order a final hearing. The purpose of a hearing ordered under this subdivision is to determine if the individual is:

(A) mentally ill and either dangerous or gravely disabled; and

(B) in need of temporary or regular commitment.

(b) A hearing ordered under subsection (a) must be held not later than two (2) days after the order.
As added by P.L.2-1992, SEC.20.

IC 12-26-5-10

Sec. 10. (a) A physician's statement may be introduced into evidence at the preliminary hearing held under section 9(a)(2) of this chapter without the presence of the physician.

(b) A finding of probable cause may not be entered at a preliminary hearing unless there is oral testimony:

(1) subject to cross-examination; and

(2) of at least one (1) witness who:

(A) has personally observed the behavior of the individual; and

(B) will testify to facts supporting a finding that there is probable cause to believe that the individual is in need of temporary or regular commitment.

(c) At the conclusion of the preliminary hearing, if the court does not find probable cause, the individual shall be immediately discharged.

(d) If the court finds at the conclusion of the preliminary hearing probable cause to believe that the individual needs temporary or regular commitment, the court shall order the detention of the individual in an appropriate facility pending a final hearing.
As added by P.L.2-1992, SEC.20.

IC 12-26-5-11

Sec. 11. (a) A final hearing required by section 10(d) of this chapter shall

be held within ten (10) days of the date of the preliminary hearing.

(b) At a final hearing, an individual may not be found in need of temporary or regular commitment unless at least one (1) physician who has personally examined the individual testifies at the hearing. This testimony may be waived by the individual if the waiver is voluntarily and knowingly given.

(c) If an individual has not previously been the subject of a commitment proceeding, the court may order only a temporary commitment.

(d) If an individual has previously been the subject of a commitment proceeding, the court may order a regular commitment if a longer period of treatment is warranted.

As added by P.L.2-1992, SEC.20.

IC 12-26-5-12

Sec. 12. If it is determined that there was not probable cause to believe that an individual was mentally ill and dangerous when taken into custody and transported to the facility to be detained, the costs of transportation to and care and maintenance in the facility during the period of detention shall be paid by the county in which the individual was taken into custody.

As added by P.L.2-1992, SEC.20.

IC 12-26-6

Chapter 6. Temporary Commitment

IC 12-26-6-1

Sec. 1. An individual who is alleged to be mentally ill and either dangerous or gravely disabled may be committed to a facility for not more than ninety (90) days under this chapter.
As added by P.L.2-1992, SEC.20.

IC 12-26-6-2

Sec. 2. (a) A commitment under this chapter may be begun by any of the following methods:

(1) Upon request of the superintendent under IC 12-26-3-5.

(2) An order of the court having jurisdiction over the individual following emergency detention.

(3) Filing a petition with a court having jurisdiction in the county:

(A) of residence of the individual; or

(B) where the individual may be found.

(b) A petitioner under subsection (a)(3) must be at least eighteen (18) years of age.

(c) A petition under subsection (a)(3) must include a physician's written statement stating both of the following:

(1) The physician has examined the individual within the past thirty (30) days.

(2) The physician believes the individual is:

(A) mentally ill and either dangerous or gravely disabled; and

(B) in need of custody, care, or treatment in an appropriate facility.
As added by P.L.2-1992, SEC.20.

IC 12-26-6-3

Sec. 3. (a) Notice of a hearing under this chapter shall be given to all of the following:

(1) The individual.

(2) The petitioner.

(3) The superintendent or the chief executive officer of a facility having care or custody of the individual.

(b) The notice required by subsection (a) must state the time, place, and date of the hearing.
As added by P.L.2-1992, SEC.20.

IC 12-26-6-4

Sec. 4. (a) Within three (3) days after a proceeding is begun under this chapter, the court shall enter an order setting a hearing date.

(b) If the proceeding was begun under section 2(a)(3) of this chapter, the hearing date set under subsection (a) must be more than one (1) day but less

than fourteen (14) days from the date of notice.

(c) If the proceeding was begun under section 2(a)(1) or 2(a)(2) of this chapter, the hearing shall be held within ten (10) days after issuance of the order.

As added by P.L.2-1992, SEC.20.

IC 12-26-6-5

Sec. 5. The court may hold the hearing at a facility or other suitable place not likely to have a harmful effect on the individual's health or well-being.

As added by P.L.2-1992, SEC.20.

IC 12-26-6-6

Sec. 6. The court may appoint a physician to do the following:

(1) Examine the individual.

(2) Report, before the hearing, the physician's opinion as to the following:

(A) Whether the individual is mentally ill and either dangerous or gravely disabled.

(B) Whether the individual needs temporary commitment to a facility for diagnosis, care, and treatment.

As added by P.L.2-1992, SEC.20.

IC 12-26-6-7

Sec. 7. If a report made under section 6 of this chapter is that the individual is not either dangerous or gravely disabled, the court may terminate the proceedings and dismiss the petition. Otherwise, the hearing shall proceed as scheduled or as continued by the court.

As added by P.L.2-1992, SEC.20.

IC 12-26-6-8

Sec. 8. (a) If, upon the completion of the hearing and consideration of the record, the court finds that the individual is mentally ill and either dangerous or gravely disabled, the court may order the individual to:

(1) be committed to an appropriate facility; or

(2) enter an outpatient treatment program under IC 12-26-14 for a period of not more than ninety (90) days.

(b) The court's order must require that the superintendent of the facility or the attending physician file a treatment plan with the court within fifteen (15) days of the individual's admission to the facility under a commitment order.

(c) If the commitment ordered under subsection (a) is to a state institution administered by the division of mental health and addiction, the record of commitment proceedings must include a report from a community mental health center stating both of the following:

(1) That the community mental health center has evaluated the individual.

(2) That commitment to a state institution administered by the division of mental health and addiction under this chapter is appropriate.

(d) The physician who makes the statement required by section 2(c) of this chapter may be affiliated with the community mental health center that submits to the court the report required by subsection (c).

(e) If the commitment is of an adult to a research bed at Larue D. Carter Memorial Hospital as set forth in IC 12-21-2-3, the report from a community mental health center is not required.

(f) If a commitment ordered under subsection (a) is to a state institution administered by the division of disability, aging, and rehabilitative services, the record of commitment proceedings must include a report from a service coordinator employed by the division of disability, aging, and rehabilitative services stating that, based on a diagnostic assessment of the individual, commitment to a state institution administered by the division of disability, aging, and rehabilitative services under this chapter is appropriate.

As added by P.L.2-1992, SEC.20. Amended by P.L.40-1994, SEC.57; P.L.6-1995,
SEC.24; P.L.24-1997, SEC.57; P.L.215-2001, SEC.72.

IC 12-26-7

Chapter 7. Regular Commitment

IC 12-26-7-1

Sec. 1. This chapter applies to a proceeding for commitment of an individual:

(1) alleged to be mentally ill and either dangerous or gravely disabled; and

(2) whose commitment is reasonably expected to require custody, care, or treatment in a facility for more than ninety (90) days.

As added by P.L.2-1992, SEC.20.

IC 12-26-7-2

Sec. 2. (a) This section does not apply to the commitment of an individual if the individual has previously been committed under IC 12-26-6.

(b) A proceeding for the commitment of an individual who appears to be suffering from a chronic mental illness may be begun by filing with a court having jurisdiction a written petition by any of the following:

(1) A health officer.

(2) A police officer.

(3) A friend of the individual.

(4) A relative of the individual.

(5) The spouse of the individual.

(6) A guardian of the individual.

(7) The superintendent of a facility where the individual is present.

(8) A prosecuting attorney in accordance with IC 35-36-2-4.

(9) A prosecuting attorney or the attorney for a county office if civil commitment proceedings are initiated under IC 31-34-19-3 or IC 31-37-18-3.

As added by P.L.2-1992, SEC.20. Amended by P.L.4-1993, SEC.203; P.L.5-1993,
SEC.216; P.L.1-1997, SEC.86.

IC 12-26-7-3

Sec. 3. (a) A petition filed under section 2 of this chapter must include a physician's written statement that states both of the following:

(1) The physician has examined the individual within the past thirty (30) days.

(2) The physician believes that the individual is:

(A) mentally ill and either dangerous or gravely disabled; and

(B) in need of custody, care, or treatment in a facility for a period expected to be more than ninety (90) days.

(b) Except as provided in subsection (d), if the commitment is to a state institution administered by the division of mental health and addiction, the record of the proceedings must include a report from a community mental health center stating both of the following:

(1) The community mental health center has evaluated the individual.

(2) Commitment to a state institution administered by the division of mental health and addiction under this chapter is appropriate.

(c) The physician who makes the statement required by subsection (a) may be affiliated with the community mental health center that makes the report required by subsection (b).

(d) If the commitment is of an adult to a research bed at Larue D. Carter Memorial Hospital, as set forth in IC 12-21-2-3, the report from a community mental health center is not required.

(e) If a commitment ordered under subsection (a) is to a state institution administered by the division of disability, aging, and rehabilitative services, the record of commitment proceedings must include a report from a service coordinator employed by the division of disability, aging, and rehabilitative services stating that, based on a diagnostic assessment of the individual, commitment to a state institution administered by the division of disability, aging, and rehabilitative services under this chapter is appropriate.

As added by P.L.2-1992, SEC.20. Amended by P.L.40-1994, SEC.58; P.L.6-1995,
SEC.25; P.L.24-1997, SEC.58; P.L.215-2001, SEC.73.

IC 12-26-7-4

Sec. 4. (a) Upon receiving:

(1) a petition under section 2 of this chapter; or

(2) a report under IC 12-26-6-11 that recommends treatment in a facility for more than ninety (90) days;

the court shall enter an order setting a hearing date.

(b) If an individual is currently under a commitment order, the hearing required by subsection (a) must be held before the expiration of the current commitment period. Notice of a hearing under this subsection shall be given to the individual and all other interested persons at least five (5) days before the hearing date.

(c) The rights of an individual who is the subject of a proceeding under this chapter and of a petitioner are the same as provided in IC 12-26-6.

(d) Hearing procedures are the same as those provided in IC 12-26-6.

As added by P.L.2-1992, SEC.20.

IC 12-26-7-5

Sec. 5. (a) If at the completion of the hearing and the consideration of the record an individual is found to be mentally ill and either dangerous or gravely disabled, the court may enter either of the following orders:

(1) For the individual's custody, care, or treatment, or continued custody, care, or treatment in an appropriate facility.

(2) For the individual to enter an outpatient therapy program under IC 12-26-14.

(b) An order entered under subsection (a) continues until any of the following occurs:

(1) The individual has been:

(A) discharged from the facility; or
(B) released from the therapy program.
(2) The court enters an order:
(A) terminating the commitment; or
(B) releasing the individual from the therapy program.
As added by P.L.2-1992, SEC.20.

IC 35-35

ARTICLE 35. PLEADING AND PROCEDURE

IC 35-35-1
Chapter 1. Pleas

IC 35-35-1-1
Sec. 1. A plea of guilty, or guilty but mentally ill at the time of the crime, shall not be accepted from a defendant unrepresented by counsel who has not freely and knowingly waived his right to counsel.
As added by Acts 1981, P.L.298, SEC.4.
IC 35-35-1-2
Sec. 2. (a) The court shall not accept a plea of guilty or guilty but mentally ill at the time of the crime without first determining that the defendant:
(1) understands the nature of the charge against him;
(2) has been informed that by his plea he waives his rights to:
(A) a public and speedy trial by jury;
(B) confront and cross-examine the witnesses against him;
(C) have compulsory process for obtaining witnesses in his favor; and
(D) require the state to prove his guilt beyond a reasonable doubt at a trial at which the defendant may not be compelled to testify against himself;
(3) has been informed of the maximum possible sentence and minimum sentence for the crime charged and any possible increased sentence by reason of the fact of a prior conviction or convictions, and any possibility of the imposition of consecutive sentences; and
(4) has been informed that if:
(A) there is a plea agreement as defined by IC 35-35-3-1; and
(B) the court accepts the plea;
the court is bound by the terms of the plea agreement.
(b) A defendant in a misdemeanor case may waive the rights under subsection (a) by signing a written waiver.
(c) Any variance from the requirements of this section that does not violate a constitutional right of the defendant is not a basis for setting aside a plea of guilty.
As added by Acts 1981, P.L.298, SEC.4. Amended by P.L.179-1984, SEC.1; P.L.313-1985, SEC.1.
IC 35-35-1-3
Sec. 3. (a) The court shall not accept a plea of guilty or guilty but mentally ill at the time of the crime without first determining that the plea is voluntary. The court shall determine whether any promises, force, or threats were used to obtain the plea.
(b) The court shall not enter judgment upon a plea of guilty or guilty but mentally ill at the time of the crime unless it is satisfied from its examination of the defendant or the evidence presented that there is a factual basis for the plea.

(c) A plea of guilty or guilty but mentally ill at the time of the crime shall not be deemed to be involuntary under subsection (a) solely because it is the product of an agreement between the prosecution and the defense.

As added by Acts 1981, P.L.298, SEC.4. Amended by P.L.320-1983, SEC.16; P.L.179-1984, SEC.2.

IC 35-35-1-4

Sec. 4. (a) A motion to withdraw a plea of not guilty for the purpose of entering a plea of guilty, or guilty but mentally ill at the time of the crime, may be made orally in open court and need not state any reason for the withdrawal of the plea.

(b) After entry of a plea of guilty, or guilty but mentally ill at the time of the crime, but before imposition of sentence, the court may allow the defendant by motion to withdraw his plea of guilty, or guilty but mentally ill at the time of the crime, for any fair and just reason unless the state has been substantially prejudiced by reliance upon the defendant's plea. The motion to withdraw the plea of guilty or guilty but mentally ill at the time of the crime made under this subsection shall be in writing and verified. The motion shall state facts in support of the relief demanded, and the state may file counter-affidavits in opposition to the motion. The ruling of the court on the motion shall be reviewable on appeal only for an abuse of discretion. However, the court shall allow the defendant to withdraw his plea of guilty, or guilty but mentally ill at the time of the crime, whenever the defendant proves that withdrawal of the plea is necessary to correct a manifest injustice.

(c) After being sentenced following a plea of guilty, or guilty but mentally ill at the time of the crime, the convicted person may not as a matter of right withdraw the plea. However, upon motion of the convicted person, the court shall vacate the judgment and allow the withdrawal whenever the convicted person proves that withdrawal is necessary to correct a manifest injustice. A motion to vacate judgment and withdraw the plea made under this subsection shall be treated by the court as a petition for postconviction relief under the Indiana Rules of Procedure for Postconviction Remedies. For purposes of this section, withdrawal of the plea is necessary to correct a manifest injustice whenever:

(1) the convicted person was denied the effective assistance of counsel;

(2) the plea was not entered or ratified by the convicted person;

(3) the plea was not knowingly and voluntarily made;

(4) the prosecuting attorney failed to abide by the terms of a plea agreement; or

(5) the plea and judgment of conviction are void or voidable for any other reason.

The motion to vacate the judgment and withdraw the plea need not allege, and it need not be proved, that the convicted person is innocent of the crime charged or that he has a valid defense.

(d) A plea of guilty, or guilty but mentally ill at the time of the crime, which is not accepted by the court or is withdrawn shall not be admissible as evidence in any criminal, civil, or administrative
proceeding.

(e) Upon any motion made under this section, the moving party has the burden of establishing his grounds for relief by a preponderance of the evidence. The order of the court upon a motion made under subsection (b) or (c) of this section shall constitute a final judgment from which the moving party or the state may appeal as otherwise provided by law. The order of the court upon a motion made under subsection (a) of this section is not a final judgment and is not appealable but is reviewable upon appeal from a final judgment subsequently entered.

As added by Acts 1981, P.L.298, SEC.4. Amended by Acts 1982, P.L.204, SEC.25; P.L.320-1983, SEC.17.

IC 35-36-2

Chapter 2. Affirmative Defense of Insanity or Mental Illness; Pleadings, Orders, and Findings

IC 35-36-2-1

Sec. 1. When the defendant in a criminal case intends to interpose the defense of insanity, he must file a notice of that intent with the trial court no later than:
(1) twenty (20) days if the defendant is charged with a felony; or
(2) ten (10) days if the defendant is charged only with one (1) or more misdemeanors;
before the omnibus date. However, in the interest of justice and upon a showing of good cause, the court may permit the filing to be made at any time before commencement of the trial.

As added by Acts 1981, P.L.298, SEC.5. Amended by Acts 1982, P.L.204, SEC.29.

IC 35-36-2-2

Sec. 2. At the trial of a criminal case in which the defendant intends to interpose the defense of insanity, evidence may be introduced to prove the defendant's sanity or insanity at the time at which the defendant is alleged to have committed the offense charged in the indictment or information. When notice of an insanity defense is filed, the court shall appoint two (2) or three (3) competent disinterested psychiatrists, psychologists endorsed by the state psychology board as health service providers in psychology, or physicians, at least one (1) of whom must be a psychiatrist, to examine the defendant and to testify at the trial. This testimony shall follow the presentation of the evidence for the prosecution and for the defense, including testimony of any medical experts employed by the state or by the defense. The medical witnesses appointed by the court may be cross-examined by both the prosecution and the defense, and each side may introduce evidence in rebuttal to the testimony of such a medical witness.

As added by Acts 1981, P.L.298, SEC.5. Amended by P.L.321-1983, SEC.2; P.L.19-1986, SEC.59; P.L.149-1987, SEC.119.

IC 35-36-2-3

Sec. 3. In all cases in which the defense of insanity is interposed, the jury (or the court if tried by it) shall find whether the defendant is:
(1) guilty;
(2) not guilty;
(3) not responsible by reason of insanity at the time of the crime; or
(4) guilty but mentally ill at the time of the crime.

As added by Acts 1981, P.L.298, SEC.5.

IC 35-36-2-4

Sec. 4. Whenever a defendant is found not responsible by reason of insanity at the time of the crime, the prosecuting attorney shall file a written petition with the court under IC 12-26-6-2(a)(3) or under IC 12-26-7. If a petition is filed under IC 12-26-6-2(a)(3), the court shall hold a commitment hearing under IC 12-26-6. If a petition is filed under IC 12-26-7, the court shall hold a commitment hearing under IC 12-26-7. The hearing shall be conducted at the earliest opportunity after the finding of not responsible by reason of insanity at the time of the crime, and the defendant shall be detained in custody until the completion of the hearing. The court may take judicial notice of evidence introduced during the trial of the defendant and may call the physicians appointed by the court to testify concerning whether the defendant is currently mentally ill and dangerous or currently mentally ill and gravely disabled, as those terms are defined by IC 12-7-2-96 and IC 12-7-2-130(a)(1). The court may subpoena any other persons with knowledge concerning the issues presented at the hearing. The defendant has all the rights provided by the provisions of IC 12-26 under which the petition against the defendant was filed. The prosecuting attorney may cross-examine the witnesses and present relevant evidence concerning the issues presented at the hearing.

As added by Acts 1981, P.L.298, SEC.5. Amended by P.L.200-1983, SEC.4; P.L.2-1992, SEC.869.

IC 35-36-2-5

Sec. 5. (a) Except as provided by subsection (e), whenever a defendant is found guilty but mentally ill at the time of the crime or enters a plea to that effect that is accepted by the court, the court shall sentence the defendant in the same manner as a defendant found guilty of the offense.

(b) Before sentencing the defendant under subsection (a), the court shall require the defendant to be evaluated by a physician licensed under IC 25-22.5 who practices psychiatric medicine, a licensed psychologist, or a community mental health center (as defined in IC 12-7-2-38). However, the court may waive this requirement if the defendant was evaluated by a physician licensed under IC 25-22.5 who practices psychiatric medicine, a licensed psychologist, or a community mental health center and the evaluation is contained in the record of the defendant's trial or plea agreement hearing.

(c) If a defendant who is found guilty but mentally ill at the time of the crime is committed to the department of correction, the defendant shall be further evaluated and then treated in such a manner as is psychiatrically indicated for the defendant's mental illness. Treatment may be provided by:

(1) the department of correction; or

(2) the division of mental health and addiction after transfer under IC 11-10-4.

(d) If a defendant who is found guilty but mentally ill at the time of the crime is placed on probation, the court may, in accordance with IC 35-38-2-2.3, require that the defendant undergo treatment.

(e) As used in this subsection, "mentally retarded individual" has the meaning set forth in IC 35-36-9-2. If a court determines under IC 35-36-9 that a defendant who is charged with a murder for which the state seeks a death sentence is a mentally retarded individual, the court shall sentence the defendant under IC 35-50-2-3(a).

As added by Acts 1981, P.L.298, SEC.5. Amended by P.L.320-1983, SEC.21; P.L.1-1991, SEC.191; P.L.2-1992, SEC.870; P.L.1-1993, SEC.239; P.L.158-1994, SEC.2; P.L.121-1996, SEC.3; P.L.215-2001, SEC.108.

IC 35-36-3
Chapter 3. Comprehension to Stand Trial

IC 35-36-3-1

Sec. 1. (a) If at any time before the final submission of any criminal case to the court or the jury trying the case, the court has reasonable grounds for believing that the defendant lacks the ability to understand the proceedings and assist in the preparation of his defense, the court shall immediately fix a time for a hearing to determine whether the defendant has that ability. The court shall appoint two (2) or three (3) competent, disinterested psychiatrists, psychologists endorsed by the Indiana state board of examiners in psychology as health service providers in psychology, or physicians, at least one (1) of whom must be a psychiatrist, who shall examine the defendant and testify at the hearing as to whether the defendant can understand the proceedings and assist in the preparation of the defendant's defense.

(b) At the hearing, other evidence relevant to whether the defendant has the ability to understand the proceedings and assist in the preparation of the defendant's defense may be introduced. If the court finds that the defendant has the ability to understand the proceedings and assist in the preparation of the defendant's defense, the trial shall proceed. If the court finds that the defendant lacks this ability, it shall delay or continue the trial and order the defendant committed to the division of mental health and addiction, to be confined by the division in an appropriate psychiatric institution.

As added by Acts 1981, P.L.298, SEC.5. Amended by P.L.321-1983, SEC.3; P.L.19-1986, SEC.60; P.L.2-1992, SEC.871; P.L.215-2001, SEC.109.

IC 35-36-3-2

Sec. 2. Whenever the defendant attains the ability to understand the proceedings and assist in the preparation of the defendant's defense, the division of mental health and addiction, through the superintendent of the appropriate psychiatric institution, shall certify that fact to the proper court, which shall enter an order directing the sheriff to return the defendant. The court may enter such an order immediately after being sufficiently advised of the defendant's attainment of the ability to understand the proceedings and assist in the preparation of the defendant's defense. Upon the return to court of any defendant committed under section 1 of this chapter, the court shall hold the trial as if no delay or postponement had occurred.

As added by Acts 1981, P.L.298, SEC.5. Amended by P.L.2-1992, SEC.872; P.L.215-2001, SEC.110.

IC 35-36-3-3

Sec. 3. Within ninety (90) days after a defendant's admittance to a psychiatric institution, the superintendent of the psychiatric institution shall certify to the proper court whether the defendant has a substantial probability of attaining the ability to understand the proceedings and assist in the preparation of the defendant's defense within the foreseeable future. If a substantial probability does not exist, the division of mental health and addiction shall initiate regular commitment proceedings under IC 12-26. If a substantial probability does exist, the division of mental health and addiction shall retain the defendant:

(1) until the defendant attains the ability to understand the proceedings and assist in the preparation of the defendant's defense and is returned to the proper court for trial; or

(2) for six (6) months from the date of the defendant's admittance;

whichever first occurs.

As added by Acts 1981, P.L.298, SEC.5. Amended by P.L.2-1992, SEC.873; P.L.215-2001, SEC.111.

IC 35-36-3-4

Sec. 4. If a defendant who was found under section 3 of this chapter to have had a substantial probability of attaining the ability to understand the proceedings and assist in the preparation of the defendant's defense has not attained that ability within six (6) months after the date of the defendant's admittance to a psychiatric institution, the division

of mental health and addiction shall institute regular commitment proceedings under IC 12-26.

As added by Acts 1981, P.L.298, SEC.5. Amended by P.L.2-1992, SEC.874; P.L.215-2001, SEC.112.